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UNIVERSITY OF ALBERTA

CONFLICT MANAGEMENT STRATEGIES OF COMMUNITY HEALTH NURSING SUPERVISORS

BY

DONALDA (DONNIE) ESTELLE MCINTOSH

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of

MASTER OF EDUCATION.

DEPARTMENT OF EDUCATIONAL ADMINISTRATION

EDMONTON, ALBERTA

FALL 1992

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Donnie L. McIntosh

5623 - 151 Street

Edmonton, Alberta

T6H 4Y6

Date: Oct. 5/92

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **CONFLICT MANAGEMENT STRATEGIES OF COMMUNITY HEALTH NURSING SUPERVISORS** submitted by **DONALDA (DONNIE) ESTELLE MCINTOSH** in partial fulfilment of the requirements for the degree of **MASTER OF EDUCATION.**

Joe Fris

Ken Ward

Arnette Anderson

Date: 29/9/92

DEDICATION

This thesis is dedicated to Frances Agnes and Donald Herald Wright, whose unwavering confidence in my abilities and constant encouragement to strive towards dreams continue to inspire me.

ABSTRACT

This study investigated how regional supervisors of eight community health centres in urban and rural settings of a western Canadian province manage challenging conflicts they encounter in the clinical area. Qualitative methods, including the use of semi - structured interviews and grounded theory were used to elicit an emic perspective from the informants, and to contribute to theory development in this area. A descriptive exploratory study, using symbolic interactionism and the constant comparative method was designed. Descriptions of the role of other participants in the conflict situation, the type of conflict, source of conflict, and the conflict management strategies used by the regional supervisors are reported. Ten formal interviews were conducted over a five month period, two of which were used as a pilot study. The stories and lived experiences of the regional supervisors interviewed were the major source of research data. Several themes emerged that related to conflict with respect to types, sources, skills and particularly regarding conflict management strategies used in primary health care settings. This compares with extant information on conflict, but specific strategies unique to this group emerged.

Conclusions arrived at were as follows: (a) the *nursing process* can be used as a model for conflict management, (b) supervisors are concerned with conflict management, (c) there is a high degree of satisfaction reported regarding the success of the conflict management strategies used, (d) most supervisors feel educational opportunities for conflict management should be increased via staff development and undergraduate and graduate programs, (e) supervisors frequently feel isolated and overwhelmed when facing some conflict situations. The

findings of this study have implications for the management of community health nursing services, staff development programs, nursing curricula additions, and support for middle management. Recommendations are made for further research of conflict in community health supervision.

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The study would not have been possible without the cooperation and support of the participants and the directors of the health centres involved. They are cannot be named individually (to maintain confidentiality), but I hope they recognize the intended acknowledgement. To those who participated in the study, thank you for

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CHAPTER 1

INTRODUCTION

Strife, friction, struggle, contest; these are all descriptors of conflict. Deutsch (1973, p. 10) writes that "conflict exists whenever incompatible behaviour occurs." This general definition encompasses potential, active, and passive forms of conflict. Strader, (Decker and Sullivan, 1992, p. 549) reminds us that conflict management is an expensive venture. She calculates that a system with 100 managers will devote $1 million dollars annually to conflict management alone (p.549). Community health centres, like all organizations, are not immune to the existence of conflict. There are several types and sources of conflict that regional supervisors must contend with such as:

- Differentiation via specialization
- Job interdependence
- Resource sharing
- Budget restraints
- Interpersonal relations
- Values
- Increasing complex role responsibilities.

An example of politically generated conflict regarding budget restraint measures of the past few years was the introduction by Alberta's provincial treasurer of legislated spending limits for health over the next several years as part of the new policy of fiscal restraint (Johnston, 1992). The fiscal correction due to begin in 1993

should result in an expected annual deficit reduction of 275 million dollars per year. The key target areas identified by the Executive Assistant to the Deputy Minister of Health, include institutional care, community and mental health services, physical services, institutional long term care, plus laboratory, radiology, and pharmaceutical services (personal communication, 1992). These changes in the relative availability of resources have already been a source of conflict at the health centre level of community health, and provided the impetus for the study of conflict management strategies in this research project.

There are several other sources of conflict health centre regional supervisors must deal with, and categorization and discussion of these will occur later in this report. These numerous sources of conflict demand that regional supervisors be adaptive, innovative, and skilful at implementing conflict management strategies.

Managers in many professions are familiar with conflict management; and much information comes from non-nursing areas such as business, psychology, sociology, education, and law. Regional nursing supervisors in community health nursing must, like all managers, deal with conflict as it arises despite their readiness, formal preparation, or skills. Kelley (in Ward and Price, 1991) proposes that nursing managers must be skilful negotiators to deal effectively with conflict. The current magnitude of change, induced partly by the economic climate and consequent necessary restructuring of the Canadian health care delivery system, plus the everyday operation of an organization imply the existence of conflict in organizations such as community health centres. As Gareth Morgan stated in his address to the 35th Anniversary

conference of Educational Administration at the University of Alberta (1991), "Discontinuity is the norm; therefore management must position for the impact"; and community health centre managers must utilize effective conflict management strategies to meet this challenge constructively.

Community health nurses have worked in Canada since the mid 1800s, with the numbers of practitioners increasing steadily as community services expanded (Morrison, 1983). Textbooks which provide direction for the management of community health centres are beginning to appear, and attention devoted to conflict management strategies in this field of practice is evolving, but limited (Henry, Hayden, & Richardson, 1989; Decker & Sullivan, 1992; Ward & Price, 1991). This deficiency may be due to a variety of factors: the absence of research regarding community health supervision; the limited publications of regional supervisors regarding their work, and lack of information about the role of the regional supervisor (See Appendix A for a description of the duties and responsibilities of community health nursing managers). Morrison (1983, p. 175) categorized the Community health nurse managers' role behaviour into four main areas: interpersonal, informational, decisional, and scholarly/professional activities.

The intent of this research was to examine conflicts encountered by regional supervisors, to expand the existing information base about community health nursing supervision, and to discover if a typology of conflict management strategies used by this group could be identified. The many types and sources of conflict these supervisors inevitably face require flexibility, adaptability, and skilfullness. Cameron, cited in

Hall (1989, p.1) predicts, "adaptive strategies should constitute a critical concern of future managers." Learning to maximize the potential benefits of conflict is the message several popular writers on the topic of conflict suggest (Deutsch, 1983, Fischer & Ury, 1991, Fischer & Brown, 1988, DeBono, 1985, and Handy, 1991). Lindelow (cited in Smith et al., 1981) defines conflict as, "the clash, competition, or mutual interference of opposing or incompatible forces or qualities." Deutsch (1973, p.10) states that, "conflict exists whenever incompatible activities occur." Hambrick (cited by Chaffee, 1985) sees strategy as multidimensional and situational, and as varying by industry. The Gage Canadian Dictionary (1973, p.1093) defines strategy as "the skilful planning and management of anything." Chaffee (1985) describes strategy as linear, adaptive, and interpretive.

> In linear strategy, leaders of the organization plan how they will deal with competitors . . .in adaptive strategy, the organization and its parts change proactively or reactively . . .in interpretive strategy, organizational representatives convey meanings that are intended to motivate stakeholders in ways that favor the organization (p.94).

Community health centre supervisors must face daily challenges in such areas as client interests, aggregate considerations, economics and values, staff concerns, and upper management directives; but this list is by no means complete. Conflict may have destructive effects on the organization, yet can be useful with the implementation of constructive management techniques, such as motivation of those involved by setting constructive goals. Understanding the positive value of conflict empowers administrators to seek proven management approaches in their attempts to generate the beneficial effects of conflict in an

organizational environment where a dissimilarity of views, values, goals, and motivation may exist.

A pilot study conducted by this researcher in the spring of 1991 examined conflicts encountered by a school principal and a community health supervisor. The data suggested that conflict exists in both schools and community health centres, and that there were frustrations and successes with conflict management at this level of management. Further, support of upper management, and preparation of the managers in conflict management appeared to be limited to a function of practical experience. This pilot study confirmed the need for the ensuing study of the conflict management strategies of community health nursing supervisors.

Fisher and Ury (1991) and Loewen (1983) categorize conflict as substantive (intellectual), or affective (emotional), contending that knowledge of these classifications will provide insight into the organization. Recognition of these categories supports the examination of conflict management strategies as the basis for this research. Respondents interviewed for the pilot study were very willing to share intense experiences relating to conflict, and commented on the cathartic effect of relating their stories.

Several nurse researchers have addressed the issue of conflict in a variety of nursing settings; yet, to date no data exist that specifically address conflict in a community health setting. A publication issued by the Provincial Nursing Consultant for Alberta Health (1991) identified the top five major categories of Level of Dissatisfaction of nurses working in home care, community health,

community-based occupational health and registered nurses and registered practical nurses working in community mental health. The area of highest dissatisfaction among nurses was "resolution of issues" with 59% of nurses expressing dissatisfaction. This finding confirmed that conflict was an issue that demanded the concern of community health supervisors. The surge of interest in nursing conflict research in recent years (Evans, 1991; Jones, Bushardt & Cadenhead, 1990; Leininger, 1990; and Strader in Decker & Sullivan, 1992) is another indicator this is an area in need of further clarification with an emphasis on specialty areas.

PROBLEM STATEMENT

Conflict is inevitable in organizations; consequently effective management of conflict can be a powerful asset. Robbins (cited in Lindelow, 1981) describes three approaches to conflict that have evolved over time: the *traditional* view, which describes conflict as a negative force; the *behavioral* view, focusing on resolution; and the *interactionist* view, which recognizes the necessity, inevitability, and benefits of conflict in an organization. Wolcott (1983), for example, estimates that managers spend 20% of their time devoted to conflict management. Though often perceived as a negative force, conflict can be a positive factor if managed correctly (Deutsch, 1973; Loewen, 1983; Zuelke, 1983; Owens, 1987). Fenton (1988) identifies moral distress as a consequence of poorly managed conflict. Within the field of health services, Evans (1991) writes that conflict management is a fundamental issue in the recruitment and retention of nurses. She contends that

nurses are adept at negotiating, but must learn how to transfer these skills to conflict situations.

Still, although conflict management references are beginning to develop in the nursing literature, few data exist that address specific nursing specialties, such as community health. Much of the available information derives from non-nursing disciplines such as business, psychology, and education. Furthermore, there are few data available that pertain to conflicts encountered by community health supervisors, in particular whether the conflict management strategies of this group match those of other fields of practise, are unique to the setting, or are specific to particular situations and circumstances. Given the importance of conflict, this lack of role-specific information is cause for concern.

OBJECTIVES

The general purpose of this study was to examine the strategies employed by community health supervisors in a selected range of conflict situations, to determine types and sources of conflicts encountered, and to identify skills which contributed to successful conflict management. More specifically, the intent of this research was to determine if a typology of strategies used by this group could be identified, and if these strategies were unique to the setting, or highly similar to strategies reported in other disciplines.

RESEARCH QUESTION

The study of conflict potentially encompasses several aspects, but

this study examined only types of conflict encountered, sources of conflict, skills which contributed to successful management, and conflict management strategies with the major emphasis on conflict management strategies. The primary research question, therefore, was:

What conflict management strategies are employed by community health nursing regional supervisors?

Other foci of this study were addressed with the following questions:

1. How do supervisors rate the success of the strategies used?
2. What are the types and sources of conflict regional supervisors encounter, and what requisite skills are recommended?
3. How do supervisors' values affect the strategies they use in managing significant conflict situations?
4. Do regional supervisors receive adequate preparation to manage conflict through formal educational level and/or via professional development?
5. Do regional supervisors have adequate support systems in place within the organization?
6. How do individuals deal with the resultant stress of conflict management on a personal level?

SIGNIFICANCE

This research was significant for a variety of reasons, among them: it may have implications for the management of community health centres, staff development programs, nursing education, and human relations. All of these areas are affected by changes in the health

care system, changing roles and expectations of supervisors and staff, and common experiences between disciplines.

Identifying the supervisors' choices of conflict management strategies is an important issue today, particularly as health care is currently undergoing the effects of broad changes which are potential sources of conflict, like financial restraint, limited resources, AIDS, an increasingly aging population, and changing family structure. This is an apparent fulfilment of Drucker's (1980) prediction of "turbulent times ahead," thus effecting a highly demanding organizational environment.

The role of the regional supervisor requires adept management, and, as Saulo (1987) points out, nursing curricula should include a specific section on conflict management. Hall (1983, p. 4) states, "successful past strategies become encapsulated dominant problem-solving approaches for the present and there is resistance to unlearn yesterday's ideas." This research has the potential of contributing to the general information on conflict management, and of integrating interdisciplinary views on this topic. Identification of successful strategies may lead to workshops or curriculum content that will teach conflict management skills.

The findings should be of interest to community health nursing regional supervisors, their directors, nursing educators, and other specialty areas within nursing. Transference between other disciplines also may be possible, as much of the current data exist in non-nursing areas, and the principles may be applicable to other areas. It is fitting to compare the work in the area of conflict in health related

literature with previously reported data from other disciplines. Examination of interdisciplinary approaches to conflict management for their applicability to an area such as community health nursing is important as there is a paucity of literature available regarding this topic.

In sum, this study contributes to the general understanding of conflict management strategies, and specifically addresses this unexplored area in community health supervision.

ASSUMPTIONS

This study assumed that conflict exists in community health clinic settings and that supervisors must manage conflict. It also assumed that supervisors would be uninhibited in describing situations they deemed as highly conflictual, and would relate their stories so they could be studied constructively and could be compared to strategies identified in the literature. Other assumptions were that conflict management causes strain, and that conflict can, under certain conditions, be beneficial to participants.

DELIMITATIONS

In an attempt to identify conflict management strategies of a significant nature, the critical incident approach was applied. Respondents were asked to relate an incident they considered particularly challenging, and out-of-the-ordinary. The expected result of this approach was that a variety of strategies would be identified. Attention was not devoted to effects other than on the participants,

perspective of other participants in the situations, or the participants' ideologies.

Other delimitations of this study concerned: geographical area, population, and gender. First, the study included urban and rural health centre settings in only a western Canadian province. Second, the respondents were from a stratified sample of convenience of supervisors of community health centres, with selection constrained by the subjects' willingness, time, and the researcher's travel resources. Finally, all participants were female.

LIMITATIONS

Limitations of the study included use of the technique of interviewing, and reliance on the recall of the interviewee. The only perspectives sought regarding the incidents were those of the community health centre regional supervisors. Participation was optional, with a clear explanation of the right to decline provided. The participants had the right to edit any portion of data from the interview after receiving a transcript of the interview.

OVERVIEW OF THE REPORT

This first chapter outlines the problem and the specific research questions addressed by this study. The study explores the types, sources, and skills necessary to manage conflict, and emphasizes conflict management strategies of community health nursing regional supervisors. The report also serves as a reflective voice of the supervisors regarding educational preparation, organizational

preparation, organizational support systems available, and personal strategies they used to deal with the strain associated with conflict situations.

Chapter 2 presents a review of the literature and research on conflict in health related fields and other disciplines. It examines conflict management strategies reported, theories on the topic, and provides a summary of how current literature provides a rationale for the conduct of the study.

Chapter 3 reports the design of the study, and describes the use of the critical incident technique and the grounded theory approach. Research design, data collection methods, and data analysis format complete the methodology description. This chapter also includes a review of the pilot study and explanation of the data collection and data analysis methodologies.

Chapter 4 presents the findings of this study. Information will include respondent description, details of the types, sources, and strategies of the major conflicts encountered, and how the supervisors rated their management strategies. Personal strategies will be detailed, as well as organizational support extended by senior management.

Finally, chapter 5 compares the findings of this investigation to the literature and previous research findings of the management of conflict, and summarizes the research report.

CHAPTER TWO

REVIEW OF THE LITERATURE

Conflict in organizations is inevitable, and although it is traditionally viewed as having negative effects, is also credited with the positive forces of creativity, adaptation, and stability. It provides the opportunity to integrate theory with practice, and can result in the development of management models (Borisoff & Victor, 1989). To maximize the potential of conflict, effective management strategies must be used. Many disciplines have contributed to the literature on conflict, and this chapter will review conflict as reported in the general literature and health related literature fields. In particular, it will examine types, sources of conflict, requisites and skills identified as necessary to deal with conflict, and strategies for the management of conflict.

THE GENERAL LITERATURE ON CONFLICT

Van de Vliert and Kabanoff (1991) describe Blake and Mouton's managerial grid of 1964 as the scientific theory of choice in the conflict management literature. They examined five styles of conflict management in terms of two variables: concern for people and concern for production: competing, collaborating, avoiding, accommodating, and compromising. Thomas and Kilmann (1974) and Rahim (1983) developed instruments based on these five styles to measure organizational

conflict. Van de Vliert and Kabanoff demonstrated that both instruments have a strong relationship with the Blake and Mouton theory, but suggest that improvements could be made, particularly in differentiation between collaboration and compromise, and accommodation and avoidance. They also allude to the inclusion of an examination of values as a recommendation for new questionnaires.

Types

Schmuck, cited in Lindelow (1981) categorizes types of conflict as being a function of situation (realities), target (goals, objectives and values), and proposals (change). Conflict can also be classed according to intensity (Bailey, cited in Lindelow) with regard to items such as petty personality conflicts, program and budget matters, and legitimacy of the regime.

Likert and Likert (1976) define two types of conflict: substantive (rooted in the task) and affective (emotional aspects). Deutsch (1973) associates all conflict with contentious activity. Rapoport (1974) types conflict as exogenous - when no super system is available to exercise control, and endogenous - where the conflict is part of a larger issue-oriented system versus a structure-oriented system.

Role conflict is frequently mentioned as a type (e.g., Deutsch, 1973, Handy, 1976, Loewen 1983). Daresh (1988) categorizes role conflict into the following: interrole conflict, interreference group, intrareference group, and role-personality conflict. De Bono (1985) types conflict into four main factors: fear, force, fair, and funds, recognizing much overlap exists between factors. Clearly, a variety of

factors contribute to the typing of conflict.

Sources

The general literature identifies several factors as potential sources of conflict. These are summarized below and listed in Table 1.

o *Communication problems*: Communication difficulties stem from lack of information shared, or to lack of effective communication skills (Lindelow and Boyd).

o *Organizational structure*: Structural factors like size of the organization, specialization, age of the facility, reward systems, and bureaucracy can be credited with being a conflict source as well as interactions that encourage conflictual encounters either at an interpersonal or intergroup level (Lindelow, Araki, Tuller, Loewen, and DeBono).

o *Human Factors*: Araki (1983) notes three personality traits that correlate with increased conflict are: authoritarianism, dogmatism, and low self esteem. Negative feelings also contribute to conflict; i.e., anger, distrust, scorn, fear or rejection (Araki, 1983). De Bono (1985) refers to sources of conflict as differing viewpoints, different wants, traditional thinking, and role expectations. Loewen (1983) identifies similar sources: competence, morality, incongruent ideals and philosophies, procedural matters, and role definitions.

o *Resources:* Araki (1983) identifies sources of conflict as policies, practices, and competitive bids for the same resources. Deutsch (1973) lists five conflict sources: resource control, preferences and nuisances, relationships, differences in values, and differences in

beliefs. Wirt (1990) and Boyd (1989) also note finance, a shortage of a needed item like resources, and reform efforts as sources.

o *Power:* Conflict may also arise in any condition where power, personal goal satisfaction, communication disharmony, and incongruity of values and beliefs exists. Boards encroaching on administrative authority also can create additional stress associated with conflict (Boyd, 1989; Wirt, 1990).

o *Change:* Tuller (1990) looks at how the rigidity of bureaucracy can hinder motivation, and thus become a source of conflict by stifling employee innovation.

Identification of these many sources of conflict confirms that conflict readily exists in all organizations, and stems from multiple origins. The most frequently identified causes of conflict are organizational structure, values, and distribution of resources.

Table 1: Sources of Conflict

Sources Authors

	*1	2	3	4	5	6	7	8	f
Communication	x		x						2
Org Structure	x	x			x		x	x	5
Human Factors									
- personality	x			x					2
- roles	x						x	x	3
- goals	x		x					x	3
- values	x		x	x			x	x	5
- beliefs	x			x			x		3
- needs	x								1
- emotions	x	x				x			3
- competence							x		1
Resources		x	x	x		x			4
Power			x			x			2
Change						x			1

* 1.Lindelow, 2.Araki, 3.Boyd, 4.Deutsch, 5.Tuller, 6.Wirt, 7.Loewen, 8.DeBono

Requisite skills

Five categories of skills were identified in the review of the general literature. These are (1) attitudes, (2) analytical skills, (3) being able to focus on the cause rather than the symptoms, (4) management techniques, and (5) prevention. The requisite skills necessary for conflict management reported in the literature are reviewed below in order of frequency, with attitudes being listed most often.

o Attitudes of optimism, honesty, knowledge of your personal tolerance levels, and courage are necessary skills for interpersonal conflict management (Kelly, 1979; Dann, 1987). Honesty, assertiveness and getting to the point are also beneficial aspects of attitude skills for managers (Dann, 1987; Weber, 1986). Weber (1986) adds to this the importance of showing respect, controlling your temper, encouraging responses, and thanking people for their input. Cooze (1990) writes that a *timely* application of humour to the organization can ease the tension of serious issues.

o Analytical skills of realistic reflection, identifying the potential for conflict, determining the real source of the conflict, inferring possible and probable outcomes, plus analyzing personal roles vis-a-vis the perspective of those involved in the conflict are admirable managerial skills (Kelly, 1979; Weber, 1986).

o Ability to focus on the causes of conflict rather than the symptoms, and isolating the main concerns are beneficial skills to bring to conflict management (Kelly, 1979; & Weber, 1986).

o Successful managers implement management techniques by starting with

the ability to listen and communicate (Kelly, 1979, Stefaniuk, 1987; Faconti and Hagerstrand, 1987; Assael, 1969; & Drucker, 1990). Stefaniuk (1987) feels workshops improve confidence in dealing with situations and suggests topics like communication, problem solving, decision making, discipline, goal setting, team building, and leadership training for such courses. Kelly (1979), Faconti and Hagerstrand (1987), and Drucker (1990) also advocate staff development via workshops and programs. Faconti and Hagerstrand present skills taught in a conflict resolution program: communication skills, non-listening techniques, use of open ended questions, and feeling questions, problem solving, brainstorming and generating multiple solutions, as well as teaching pro-active behaviour. Assael (1969) recommends equitable access to resources and consistent conflict management approaches, while Drucker and Tuller (1990) emphasize building on employee strengths, adding responsibility and providing opportunities for advancement, as well as establishing shared goals and values within the organization. Cooze, (1990) identifies requisites for conflict management as maintaining open communication channels, refraining from manipulative techniques, avoiding evaluative responses, and building a climate of trust. Familiar strategies (Toffler, 1990) are: controlling the sending and receiving of information through various tactics, like secrecy, using guided leaks, manipulating the message (and sender), skirting the issue, and sending contradictory messages, limiting access to the receiver, and sharing of the potentially dangerous information for personal protection (cover your ass). He also describes controlling information as, "massaging the message," via omissions, generalizing,

timing, and several other negative modes.

o Tuller (1990) suggests effective managers minimize conflict by establishing clear work routines and setting standards for measuring short term results. Proactive efforts, such as strategic planning motivates staff via job enrichment, achievement recognition, responsibility, and advancement.

Strategies

The materials in this section relate to general strategic principles, then to specific strategies.

General strategic principles are described by several authors. Hambrick (cited in Chaffee 1985) states that strategies are multidimensional, situational, and vary by industry. In the same article, Chaffee presents three strategy models: linear, adaptive, and interpretive. Linear strategies identify the long term goals of an organization, adopt a course of action, and allocate resources accordingly. Adaptive strategies attempt to match external opportunities and risks with the organization's capabilities; changing proactively or reactively. Interpretive strategies have managers sending motivational messages that support the organization. Techniques that work well in one situation may not transfer well to another. Strategy choice depends upon the importance of achieving personal goals, and the importance of keeping a good relationship with other people (Cooze, 1990). Robbins (cited in Lindelow, 1981) describes three philosophies of conflict management: the *traditional* (all conflicts seen as destructive), *behavioral* (concentration is on how to resolve conflict), and *interactionist* (sees

the necessity of conflict). Pondy (1969) states addressing conflict provides the feedback loop necessary for self-regulation and stability.

Fisher and Ury (1991) compare principled negotiation with positional negotiation. Principled negotiation has an affective component and focus, with consideration of people's thoughts and feelings at the forefront. This approach recommends separating people from the problem; focusing on interests, not positions; generating several options; and basing the results on objective criteria. The participants become the problem solvers. Positional negotiation mixes the people problems with the facts and issues, which can force the participants into a win-lose situation and lead to the adoption of a defensive stance. The authors advise readers not to expect reciprocity; to balance emotions with reason; try to understand the other person's position; communicate (consult) before acting; be reliable; be open to persuasion and try to persuade; and accept others as worthy of your consideration (Fisher and Brown 1989, p.3).

Thomas (1976) describes two models of approaching conflict: the process model, and the structural model. Process deals with the sequence of events, and structure with the underlying conditions (Barton, 1991). There are many methods and variations on the Thomas - Kilmann model that one might adopt, but no one method is best; administrators should be able to use a variety of techniques (Lindelow & Scott, 1989). Administrators are most likely to find that each of these five methods has specific value in different situations. Matching the methods of resolution to the source of conflict requires administrative awareness of each mode and careful analysis of the variables involved in

a given situation. Additional recommendations are to increase the strength of intergroup contact, to develop a goal that all groups desire, and to restructure the organization (New Mexico Research and Study Council 1983).

Specific strategic approaches described in the general non-health related literature frequently follow the guidelines of the Thomas Kilmann model (1972). This model defines five categories of conflict management strategies: collaboration, compromise, avoidance, domination, and accommodation (Thomas, 1976). These categories maximize productivity and minimize calamity. They are defined as follows:

o Collaboration - Attempts to satisfy both parties with a win-win approach; presenting multiple options, and being future oriented.

o Compromise - Sharing or making deals to split the difference of the stakeholders in the situation. They tend to be quick fixes and are rarely lasting.

o Avoidance - This depicts passivity, withdrawal, and retreat; the conflict remains unaddressed.

o Domination or Competition - Satisfaction of one's own concerns even at the expense of others is the goal, resulting in a win-lose situation. It is a power based approach.

o Accommodation - Others' concerns take priority over your own; elements of self-sacrifice and yielding to another's point of view are apparent.

Caldwell and Beyers (1988) found that principals and teachers preferred cooperative modes rather than competitive modes. Formisano (1987) reported that female principals preferred to compromise, and used diffusing techniques to handle conflict. Boyd (1989) and Wirt (1990)

emphasize the existence of gender as a factor in conflict management, women being less aggressive, less controlling, more collaborative and empathetic than men, but do agree these conclusions could be provocative.

Walton & McKersie (1965) have specific suggestions for controlling information:

- minimizing clues
- deliberately remaining quiet, let the opposition do most of the talking;
- appoint a spokesperson or a chairperson who controls the participation of other members of her/his team;
- "calculated incompetence" - compose the negotiating committee of people who do not have significant knowledge of their party's resistance point, or feign ignorance of crucial information;
- burying core requirements in a large number of demands.

It also can be done by deliberate communication of facts, cogent reasoning, emotional behaviour, and threats that reveal the importance of specific points that clearly illustrate what the consequences will be for participants. The communication of misinformation also can be used but has serious potential disadvantages such as backlash, jeopardized credibility, and animosity and hostility. Kinder and Cowan (1989) and Fisher and Brown (1989) recommend "better communications," as one solution to many conflictual situations, including marital. This is requisite to negotiation. What frequently results is that the attempts at improved communication have little to do with exchanging new information and everything to do with blaming and complaining. The net

effect is even more disappointment. Instead, they have found, it is more fruitful to teach the adversaries

> . . . what each of them can do themselves to enhance the quality of the [relationship] rather than reinforce futile attempts to get the other person to change . . . to identify and recognize the inaccurate and exaggerated expectations [they] hold and to take responsibility for them (p. 13).

Araki (1983) stresses the concept of a group approach to resolving conflict, and presents a three step process to achieve this: problem identification, problem analysis, and problem synthesis, with the qualifier that the climate for this comes from the energy of the leader. The technique of mind-mapping advocated by de Bono (1985) is a very useful tool in the assessment and analysis of the conflict.

Basic strategies identified by Papa and Pood (1988) are: reason, friendliness, bargaining, assertiveness, coalition formation, appealing to higher authorities, and the use of rewards and punishments.

Loewen (1983) reported several strategies used by school superintendents of education: information control, rules and regulations, reward control, denigration, coalition formation, coalition destruction, withdrawal, expressing naivete, environment control, stalling for time. Many of these strategies could be classed as manipulative, and that the superintendents capitalized on their position power, but used more commensurate tactics when dealing with those with similar power. These are similar to the strategies Handy (1976) identifies: control of information, distortion of information, use of rules and regulations, control of rewards, and denigration.

Techniques for a pro-active approach include: acting as the linking pin, managing through prevention, confrontation in open

exchanges, and the neutral third party method (Zuelke & Willerman, 1987). The case for firing can be classed as a proactive response when effects of an incident are far reaching within an organization (Singer, 1992). Using the concept of offering "brief explanations" is a strategy for managing conflict, but can lead to employees eventually feeling betrayed, with an escalation of conflict resulting (Bies, Shapiro, & Cummings, 1988).

The Alberta Teachers' Association offers teambuilding workshops that stress the coding of situational attributes, and matching situations with a course of action. Use of the Vroom-Yetton model (Owens, 1987) is useful in encouraging staff participation in the analysis of situations.

THE HEALTH RELATED LITERATURE ON CONFLICT

Conflict is a clash of opposing ideas, interests, and values (Evans, 1991). This requires an understanding of conflict and also requires skills of conflict management (Lindelow in Smith, Mazzarella & Piele, 1981). A statement by Kelley (Ward & Price 1991, p. 475) captures the essence of nursing service administration.

> Accomplishing organizational objectives according to an established timetable with a minimum of resources while influencing resolution of conflicts is a major basis for the evaluation of nursing service administrators; determining whether they are retained or released.

Because conflict is an inherent part of a supervisor's role, it is essential that the supervisor learn to manage conflict effectively and constructively. However, very little data are available that

specifically address community health nursing, existent data must be used.

Types

The common conflicts seen in nursing are role conflict, professional competency, and shared resources (Wolcott, 1983, Green and Driggers, 1989). Gibson (1986) types conflict as intergroup, intragroup, interpersonal, and intrapersonal. Strader (Decker and Sullivan, 1992) concurs with these typologies, and adds interterritorial and intraterritorial. Decker and Sullivan (1992, p. xxiii) feel conflict is influenced by the environment, structure and technology, individual characteristics, and managerial policies. Evans (1991) types conflicts encountered in nursing as conflicting special interests, differences in objectives and values, and shortages of financial and human resources. Lynch and Tiedje (1991) classify types of conflict in the client-provider relationship: values, control and information. Barton (1991) cites Cushnie in typing conflict according to facts, methods, goals and values, and implies that conflicts based on facts are more easily managed than those based on belief systems. Maher (1991) views conflict according to behaviours, tasks, and accomplishments, and not on personality. Kelley (Ward & Price, 1991, p. 478) presents a systems approach to typing conflict, with interaction between: 1) problems, issues and trends, 2) level of interaction, 3) role status, and 4) concepts. Booth presents four labels for conflict (Ward & Price, 1991): differing demands and expectations made by different people, differing values and beliefs, organizational characteristics, and role

overload, when individuals assume multiple roles such as wife, mother, nurse, community member, and member of a professional organization. The expectations for one individual are far too great. All other types listed in the general literature matched those reported in the health related literature with the exception of the point of role overload.

Sources

Wolcott (1983) and Strader (Decker and Sullivan, 1992) suggest sources of conflict are value systems, interests, goals, and objectives of participants. They felt the main causes of conflict in health care settings are lack of money and lack of people. Strader lists "antecedent" sources of conflict as conflicting goals, resources, regulations, personalities, interests, values, roles, and tasks. Stern (1982) feels conflict in nursing stems from dissatisfaction and false expectations. Professionalism must be viewed from an economic and psychological standpoint, inevitably encountering internal conflicts. Conflicts arise from a lack of fit between a person's beliefs, values, and role expectations, as well as misunderstandings, semantic differences, and subjective factors (Gibson, 1986). Noble and Rancourt (1991) cite Sullivan and Decker 's six sources of conflict in nursing; role conflict, self-worthiness, intraprofessional divisiveness, intergroup conflict, individual role conflict, and communication problems. The discrepancy between understanding ethical standards and the willingness to implement them results in conflicts in ethical decision-making (Wilkins, Macguire, Abbott and Blau, 1990).
A predominantly female workforce, relatively low pay, difficult working

conditions, lack of authority and decision making power are issues that can lead to conflict in nursing (Mason, Costello-Nikitas, Scanlan, & Magnuson 1990). Demo (1986) describes one source of conflict as message overload, in that nurses receive too many orders from too many people at all levels of authority.

The underutilization of highly educated nursing personnel surfaces as a source of intraorganizational conflict, with long term changes being dependent upon health care administration (Growe, 1991).

Results of the Community-based nursing worklife survey conducted in spring, 1991, indicated five major categories of dissatisfaction. Reported in order of ranking, they are:

1. Resolution of issues - 58.5%
2. Occupational health and safety - 35.7%
3. Workload - 32.2%
4. Communication - 31.5%
5. Scheduling - 23.3%

These categories may be sources of conflict within this work setting, though consideration that the focus of the survey was for staff, not regional supervisors, may account for the absence of items 2. and 5. from the other health related literature.

Morrison (1983) found conflict for community health nursing managers exists between responsibility to staff and programs, and responsibility to administration. She also reported these managers felt they worked in isolation.

Jones, Bushardt, and Cadenhead (1990) also identify communication and lack of experience as factors leading to conflicts. Coping with the

challenge of ethical dimensions is an important management concern (Fenton, 1988) when personal moral beliefs are involved. Maher (1991) lists several sources of conflict in nursing: dissatisfaction over existing mission statements, client care goals, interference in nursing intervention implementation, sequence and timing of nursing activities, choice of nursing interventions, interdisciplinary disputes, client reasonableness, patient care outcomes, performance appraisal process and outcomes, work allocation decisions, data collection and record keeping, and changes in routine. Booth, in Ward and Price (1991), lists four main sources of conflicts: conflicting interdisciplinary expectations, values and beliefs, inter-role conflict, and organizational characteristics such as size (p. 492).

The order of frequency of sources of conflict cited in the health related literature was: values, goals, communication, role expectations, internal professional problems such as role overload, and ethical issues. Other issues identified were no less significant, but were merely mentioned less frequently.

Requisite Skills

Personal attributes that managers should have to manage conflict include: a positive sense of self, assertiveness, problem solving ability, ability to make decisions, the ability to view situations empathetically and dispassionately, and the ability to focus on issues and behaviours rather than on persons. They must be able to take risks, negotiate, actively listen, be open and flexible, and define issues in the smallest terms (Saulo, 1987). When examining conflict, one must

consider value systems, interests, ideas, goals, and objectives. A self assessment of personal styles of conflict management, attitudes, and communication techniques is the place to start and then study a role model whose conflict managing skills you admire (Wolcott, 1983). Two critical skills that influence any approach to resolving interpersonal conflict are: 1) focus on the end result or outcome, 2) concern for the relationship (Jones, Bushardt, & Cadenhead, 1990). Evans (1991) describes several useful skills: allowing for emotional cooling off, face saving, communication skills, active listening, validation, silence, knowing when to change the setting, doing your homework, and asking for advice.

Kelley (in Ward and Price, 1991, p. 480) dissects skills into two areas; preparation skills, and strategy selection skills. She advocates the preparation skills of developing a blueprint of questions that need the right timing, content and delivery to achieve the desired purpose, and lists climate control, recognizing and reducing barriers, building trust, gaining commitment, and managing the opposer as other useful skills.

The similarities between the general literature and the health related literature was apparent from the discussion of the same categories of recommended skills of: communication skills, values, beliefs, and positive attitudes. Differences of note in the health related literature were flexibility, the addition of empathy as a skill, and reference to the ability to conceptualize.

Strategies

Several authors have written about conflict in health related settings. Table 2 illustrates trends in this area, and a brief discussion of these points follows.

Table 2: Eleven Categories of Conflict Management Strategies Identified in the Health Related Literature

*Authors	1	2	3	4	5	6	7	8	9	10	11	12
Collaboration			X	X	X	X				X	X	X
Negotiation		X								X		
Controlling		X			X	X	X	X		X	X	
Avoidance				X	X						X	
Individualizing & Flexibility	X		X		X					X		
Following a model	X	X		X	X		X			X		
Empowerment	X			X			X					x
Truthfulness			X									
Deference									X	X	X	X

* 1.Noble, 2.Saulo, 3.Veninga, 4.Gibson, 5.Okolo, 6.Jones, 7.Mason, 8.Growe, 9.Demo, 10.Evans, 11.Redland, 12.Wolcott

o *Collaboration:* Collaboration describes the cooperative or integrative problem-solving approach as creative, open and flexible, using imagination, brainstorming, and idea exchange. Nurse executive roles include strategic planning, forecasting of trends, identification of potential problems, and unleashing the creative potential within employees so that seemingly unsolvable problems can be diminished

(Veninga, 1987).

o *Negotiation:* Negotiation, or compromise or bargaining strategies include: depersonalizing issues, framing issues in terms of mutual problems, examining all reasons why the other party is reluctant to accept a proposal, and looking for small areas of agreement and working on them until a solution is found (Saulo, 1987). "Negotiation is . . .getting what you want from others while helping others get what they want too (Evans, 1991)." Taking needs, feelings and desires into consideration; both parties work together. Discussions of conflict management strategies centre mainly on union activities and a key finding, "The lesson (of the 1980 Alberta nurses' strike) is that defiance beats conciliation as a strategy by a mile" (Growe, 1991, p.142). Hibberd (1992) writes on the ultimate effect of unresolved conflict, the incidence, issues and trends of strikes by nurses. (Nursing) has a long history of passive aggressive communication (Evans, 1991).

o *Controlling:* Controlling types of management strategies include confrontation and competition. Saulo (1987) believes practitioners need to use confrontation to control their practice, and describes a method of teaching conflict resolution skills. Forcing, or the use of power is when one party has high concern for the outcome, but little concern for the relationship. Confrontation or problem solving demonstrates a high level of concern for the problem, outcome, and relationship (Jones, Bushardt, & Cadenhead, 1990).

o *Avoidance:* Avoidance denies conflict in favour of harmony, and the resulting tension causes the person to withdraw and keep encounters as

impersonal as possible (Gibson, 1986). Benign neglect is often seen in nursing; the rationale seems to be, "if the problem is ignored long enough , it will go away" (Evans, 1991).

o *Individualizing and flexibility:* Individualizing would be letting the staff know that you will do everything you can to protect jobs, as organizations do not function productively when employees worry about their jobs (Saulo, 1987).

o *Following a model:* Several models exist to address the pursuit of conflict management strategies. Thomas (1976) (described earlier) is frequently followed, (Wolcott 1983, Okolo 1985, Jones, Bushardt & Cadenhead 1990, Tomey & Poletti 1991, Barton, 1991) as in the general literature. They also endorse the use of the Johari's window, a popular communication model. Wolcott describes a bureaucratic approach, in which manipulation, bargaining, and persuasion are frequently used which often leads to hostility and resentment. Models described by Strader (in Decker and Sullivan, 1992), Kelley (in Ward & Price, 1991), and Saulo (1987) closely follow the guidelines of the *nursing process*; assessment, diagnosis, planning, implementation, and evaluation as a management plan to deal with conflict. A reproduction of Straders' model appears in Appendix E.

Strategies such as persuasion, tradeoffs, appeals, kickbacks, demands, compromises, threats payoffs, leaking information, and mutual agreements occur (Kelley in Ward & Price, 1991). Kelley recommends developing a nine step map of preparations to be worked through from your point of view and then from your opponent's.

1. assessment of philosophy of negotiation
2. goal setting
3. fact-finding
4. problems, issues and trends
5. position setting
6. strategy selection
7. tactic implementation
8. evaluation system
9. issue resolution

The cooperative or integrative problem-solving approach is creative; open, and flexible; uses imagination, brainstorming, and idea exchange; and often leads to group cohesiveness, personal growth, and personal enjoyment (Wolcott, 1983; Gibson,. Okolo (1985) cites the concepts of win-lose, lose-lose, and win-win strategies from Guetzgow & Gyr (1954).

Evans (1991) cites Gharajedaghi who formulated a systems theory application to conflict resolution. Maher (1991) also advocates a systems approach to conflict management, using the phases of clarification, planning, implementation and evaluation. The four steps outlined are: solve, resolve, absolve and dissolve.

One model proposed incorporates three distinct modes of *knowing:* empirical (senses and reasoning), noetic (intuitive feeling and abductive reasoning), and rational (defined standards or rules) (Noble & Rancourt, 1991). The writers reported the knowledge accessing style of nurses follows an ERN pattern, empirical over rational over noetic, though they recognized one common profile does not apply to all nurses, and differences may result in conflict. Administrators who educate

staff about the differences in perception help staff understand that reality is not always perceived the same way by all participants.

o *Empowerment:* Empowerment of staff, instead of being a trendy word, can be a forceful tool in the organization. The leader needs to share a dream and bring along followers to share the dream. When discussing bad times, share the good news first, then the bad news, then follow up with the good news (Veninga, 1987). Though studies show nurses should play a greater role in decision making in the workplace, the assumption should not be made that they have the confidence or skills for making changes that will be politically astute or effective. Empowerment dimensions include fostering positive self-esteem, developing self-efficacy, and being politically and socially conscious (Beck, 1983). Empowerment is a confirmation of self, one's values and dreams, and ones' abilities. It is an energizing experience that mobilizes ones' resources and enables change in constructive and creative ways. It results in a sense of hope, excitement, and direction, and is essential for the health and growth of nurses (Mason, Costello-Nikitas, Scanlan, & Magnuson, 1990). Mason et al. developed a workshop with discussions of how to get and use power, creating images of power, overcoming resistance to change, networking, doing political assessments, developing a support base, building coalitions, using confrontation, and negotiating.

Kerr (1988) describes the basic necessities for effective political action as understanding both formal and informal systems in the organization. She encourages nurses to be risk-takers, to hone communication skills, and to be aware of accurate timing when implementing political strategies.

Boyd (1991) recommends the personal strategies of developing hardiness, engaging social support, and part-taking in activity/exercise.

Schatzki and Tamborlane (1988) provide rules to follow to implement the graduated power mode: use less power first, use as little power as possible, always try to go back to a problem solving approach. They suggest: first discuss, then threaten, then take action, but feel the graduated power model helps to soften the effect of power.

o *Truthfulness:* Veninga (1987) advocates being truthful with personnel about the magnitude of problems and the implementation of steps underway to resolve them. Be truthful, but say no more than necessary to diminish fear and create understanding. Let staff know you are doing everything possible to protect their jobs, and ask the advice of experts.

o *Deference:* Conflict resolution should begin with self assessment, putting emphasis on personal attitude, and developing an awareness of social pressure, i.e., deference to physicians (Redland, 1983). Nurses feel they need to use tact and diplomacy and show respect for the doctor's authority (Demo, 1986). Jones (1991) writes about the benefits of contract writing to develop common ground between managers and staff as a means of decreasing conflict and improving relationships.

Morrison (1983) found that the role of the nursing manager was not clearly defined, and the multiple role expectations inconsistently defined. Methods for conflict resolution suggested by Wolcott are: smoothing, majority rule, compromise, and avoidance (1983).

Booth cites Bartol's (Ward & Price, 1991) findings about nurses'

choices of conflict strategies of nurses in ten different hospitals: collaboration, confrontation, compromise (bargaining), forcing, accommodation (smoothing), and avoiding.

Johnson and Bergmann (Ward & Price, 1991, pp.485 - 486) advocate: building your own team, establishing alliances with both superiors and peers, using all possible channels of communication, maintaining a flexible position and manoeuvrability, being courteous, increasing visibility, networking, mentoring, and coopting.

Eason, Spickerman, and Lee (1990) identify political strategies like coalition formation, bargaining, lobbying, posturing, bluffing, and increased visibility. They say building a power base with knowledge, expertise, and relationships is a proactive approach.

Summary

Many ideas reported in the general literature match those of the health related literature. Twenty specific strategies described in the general and health related literature were matched. The twenty strategies that appeared in the general and health related literature were:

collaboration	forcing	compromise	empowerment
coalition formation	avoidance	proactive steps	smoothing
assessment skills	accommodation	confrontation	silence
staff development	mentoring	controlling	courtesy
bargaining	negotiation	individualizing	flexibility

Strategies that did not match were: elimination, denigration, and the development of workshops; and deference, lobbying, bluffing, and

maintaining visibility.

Research in the area of conflict in health related disciplines is recommended, particularly as there is a paucity of information that relates specifically to specialty areas of nursing. For example, conflicts encountered in an intensive care unit vary significantly from those encountered in a community health setting.

The strategies identified in this review of the literature raise several questions:

1. What types of conflict occur in community health settings, and to what extent do they correspond to the types described in the literature?
2. Who is most affected by these conflicts?
3. What strategies are used to manage conflicts? How successful are they?
4. Is gender a factor in strategy choice?
5. Should nursing education curricula contain a component devoted to conflict management?

CONCLUSION

The similarities of the two literature sources with respect to the identification of communication and organizational structure as sources of conflict are of interest. The emphasis on the effects of resource allocation, power, and the implementation of change in the health related literature was less than what appeared in the general literature. Several points of interest occurred with the identification

of such issues as message overload, underutilization of skills, expanding roles, the lack of authority, and ethical issues as potential sources of conflict. This review of the literature has indicated very little information exists on conflict management in the specialty areas of nursing, such as community health. Successful management of conflict is achieved when strategies are matched to the setting. As Strader (Decker and Sullivan, 1992) aptly points out, the literature does not indicate which strategies are most effective or when intervention is necessary. Researching the strategies used by administrators will permit better grounded anticipatory planning from a tested perspective.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

INTRODUCTION

The first chapter described the issue of the force of conflict in organizations, and the absence of information regarding conflict management strategies used by Community Health Centre Regional Supervisors. Subsequently, the review of the literature revealed a growing interest in health related fields regarding this topic, and an abundance of information that presently exists in other disciplines. This chapter presents the methodology adopted for this study, with a plan of the study, including study design, description of the pilot study, ethical considerations, explanation of data collection technique, analysis, and verification of findings.

The qualitative research design for the scientific inquiry of this study is of a descriptive, exploratory nature. The major purpose of this research was to describe the "lived experiences" of supervisors as they encountered a critical incident perceived as conflictual in their health centres, and to ascertain conflict management strategies they used. The critical incident technique developed by John Flanagan (cited in Borg & Gall,1989) involves an individual describing a critical incident that person had been involved in to determine if the behaviours and skills observed can be predicted in similar groups. Additional enquiry revolves around whether strategies chosen corresponded to those

identified in the literature, either in health or non-health related literature.

The design of this descriptive exploratory study falls within the naturalistic research paradigm as described by Guba and Lincoln (1982), Owens (1987), Berg (1989), Borg and Gall (1989), Elliot (1990), van Manen (1990), and Strauss and Corbin (1990). Borg & Gall (1989, pp. 385-386) define qualitative research from a perspective of naturalistic inquiry; it is carried out in a natural setting, conducted by humans, nontypical subjects are included, data are studied inductively to reveal unanticipated outcomes, theory that is grounded in the data is developed, the design emerges as the research progresses, and the subject plays a role in interpreting outcomes. Elliot (1990, p. 78) states, "Naturalistic research allows for contingencies and important side effects, and permits sensitivity to the process of a situation, and hence, a contextual richness can be provided." The technique of qualitative analysis used is known as "grounded theory" (Strauss & Corbin, 1990). In this approach, the researcher doesn't try to fit the data to his/her theory, but lets the theory, grounded in data, surface during constant comparative analysis. The findings are grounded in real world patterns that emerge from close involvement and direct contact with the real world (Patton, 1990).

This study asked, "What conflict management strategies are used by community health centre regional supervisors?" The aim was to determine the level of understanding and ease of implementation of conflict management in a community health centre setting, and how community health nursing regional supervisors faced challenging situations. To

answer the question, symbolic interactionism was selected to guide the research. It stresses the emergent nature of situations and people derive meaning through their individual subjective interpretation. Close involvement of the supervisors in this setting permits the presentation of an accurate account (Pansegrau, 1983). Therefore, this study gained an understanding of regional supervisors' perceptions of strategies used to manage conflict.

ASSUMPTIONS

In this study, assumptions were: the chosen method would accurately reflect the strategies supervisors used for conflict management; the respondents would relate their stories accurately, openly, and honestly; they chose incidents that truly reflected a conflict situation; and the choices of strategies adopted by the regional supervisors were highly influenced by the organizational factors in which they occurred (Selznick, 1949, cited in Owens, 1987, p.179).

METHOD

Van Manen (1990) states that, "to do research is to examine the way we experience the world, to want to know the world in which we live as human beings" (p.5). Naturalistic research uses the day-to-day world to make us aware of what is real. It is a human science that studies the world as we immediately experience it, and gains insight without the use of preconceived models or classifications, and explores the recalled phenomena grounded in lived experience. This is a human science applied to a human world and, in this case, is meant to develop an understanding

of how supervisors manage conflict through the help of a theory or model.

The researcher adopted a qualitative approach of inductively building a theory about conflict management strategies used by community health nursing regional supervisors in actual situations. Grounded theory provides the basis for the method of analysis. One does not begin with a theory, and then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. The method uses systematic procedures for data collection and analysis to develop a theory about a phenomenon (Strauss & Corbin, 1990, p. 23-24). Theoretical sensitivity, a creative aspect of grounded theory, is the integration of the researcher's personal and professional experience with the existing literature on the topic (p.44). The emphasis in grounded theory is that themes, principles, and theory will become apparent upon analysis of the data; consequently, inductive data analyses were used. These factors were isolated and then named. Studying the lived experiences related by the supervisors permitted contemplation of how the situations affected feelings and perceptions experienced by the supervisors (van Manen, 1990).

The lived world of supervisor functioning with respect to conflict management strategies was examined in terms of day-to-day behaviour, and whether the strategies identified reflect the culture of health centres. The "rich" data sought were analyzed in terms of values and motives (Owens, 1987). Readers are reminded that qualitative research is value bound, and reflects the researcher's values in terms of topic selected,

research design, questionnaire development, data analysis, and interpretation (Lincoln and Guba, 1985).

> The interpretive examination of lived experience has this methodical feature of relating the particular to the universal, part to whole, episode to total (p.36).

In this study, the whole issue (holistic picture) of the conflict situation was studied.

RESEARCH DESIGN

Kirk and Miller (1986) describe four phases of the qualitative research "map" as Invention, Discovery, Interpretation, and Explanation.

- *Invention* covers the area of identifying the area to be studied, and gaining entry to the field. Letters of request describing the research and enlisting agency support in terms of access to regional supervisors were written to Health Unit directors, with approval granted from all those approached.
- *Discovery*, or data collection is the second phase and the interview technique using semi-structured questions was chosen. Exploratory studies of topics with little information available about them, such as the conflict management strategies of community health centre supervisors, can effectively employ a semi-structured, probing method of interviewing. Interviews help discover what is inside someone else's mind, and reveal feelings, thoughts, and intentions. Interviews allow us to enter the other person's perspective (Patton, 1990). The interview method was chosen to facilitate respondents' recall of essential data, to encourage deep explanations, and to maintain sensitivity about

time constraints and fatigue. Such an approach was used to interview respondents while audiotaping the interview. The interviews were transcribed by the researcher, then copies sent to the respondent for verification. Confidentiality was assured, and all names and locations were deleted from the transcribed copies. The researcher conducted all interviews and transcribed them, following the recommendations of Strauss & Corbin (1990). This approach assists with developing the insider's perspective and examines lived experience.

- *Interpretation*, or analysis of the data, is the point where a typology emerges, and where credibility is confirmed. The four criteria for judging how well a theory applies to a phenomenon are fit, understanding, generality, and control (Strauss & Corbin, 1990, p. 23).
- *Explanation*, is the linking together of the findings into meaningful starting points for action or further research. Development of hypotheses *from the data* illustrate and clarify the findings, describes how the concepts relate, and under what conditions they co-vary. Borg and Gall (1989) consider that these hypotheses are more grounded in the real world. Findings were related to extant knowledge. See Appendix B for a schematic depiction of the research design.

PILOT STUDY

A pilot study in the Spring of 1991 included interviews with a regional supervisor in a rural health setting and with a principal of a

rural junior high school. Both of these participants were experienced practitioners and provided several candid examples of conflicts they encountered in their respective areas. It tested the interview format, various interviewing techniques (open-ended questioning, directing, agreement, restating, and silence, to name a few) and the grounded theory approach. Identification of emergent themes was limited due to the small number interviewed, though the exercise of data analysis and testing methods for illustrating themes proved to be beneficial. This procedure led to a revision of the initial interview guidelines, provided interviewing practice, and familiarized the researcher with the mechanical operations required in audiotaping, transcribing, and use of a computer to assist in data analysis.

DATA SOURCES

The community health nursing regional supervisors were from the population of urban and rural health clinic settings in a western Canadian province. The stratified sample was one of convenience, the sampling procedure somewhat flexible, and the "snowballing" effect described by Stainback & Stainback (1988) occurred, where original respondents recruited others. Hall (1989, p.70) calls this a "modified progressive nomination technique." All possible respondents were not included in the research to facilitate variance in setting (rural/urban). The interviews were conducted from January to April, 1992., and the eight interviews were conducted in office settings at the health centres or educational settings.

ETHICAL CONSIDERATIONS

Consideration of confidentiality of the respondents was a significant concern in this study due to the sensitive nature of the topic. All references to location and identity were deleted, and anecdotal information that might identify participants was omitted from reports. Ethical approval for the study was granted by the Ethics Review Committee of the Department of Educational Administration, University of Alberta.

Participation in the study was voluntary and respondents had the opportunity to have any part of the transcript deleted during the member check. Approval from the Directors of the Health Units was sought prior to contacting potential respondents.

DATA COLLECTION

Interview scheduling was dependent upon the availability of each regional supervisor. The researcher conducted and transcribed all interviews, thus guaranteeing confidentiality. Detailed field notes were kept to describe the uniqueness of each situation, and to record non-verbal and other observations made such as the general climate of the health centre, the number and intensity of interruptions during the interview, the ease of the participant's response, and the emotional climate. Interviews lasted from 60 minutes to 90 minutes. The atmosphere of the eight interviews was casual and spontaneous. Open-ended questions were used as an interview guide to encourage respondents to volunteer as much information as possible, and were originally developed from the research question, the literature, and adapted

following the pilot study. Questions were not fixed or in a special order. The interview guideline was available to use as a reminder to the researcher, but it was found that respondents generally were very descriptive of each incident, and resort to the guidelines was seldom necessary. See Appendix C for the Interview Schedule.

DATA ANALYSIS

Data analysis begins when the data collection begins (Strauss and Corbin, 1990), and continues throughout the study, and is therefore known as the "constant comparative" method of data analysis. Grounded theory suggests three types of coding: open, axial, and selective. Open coding is the process of concept identification and development; similar events are labelled and grouped to form categories. Axial coding relates subcategories to a category. Selective coding designates the core category or central theme of a story and relates it to other categories (Strauss & Corbin, 1990).

The audiotaped interviews were transcribed by the researcher and sent to the interviewees for confirmation. When verification by the informants was received, the researcher began coding phrases, sentences, and paragraphs. Then they were analyzed for such elements as themes, concepts, characters, and items relating to strategies (Berg, 1989). The analysis was first done individually for each interview, then pooled. Use of a split screen on the computer facilitated data movement throughout the analysis. The codes collapsed to categories, and following the first collapse, 285 strategies collapsed to 107 categories. A second collapse of the data resulted in 38 categories.

The realization that additional data existed that were essential to relating a complete story initiated a return to the data for subsequent analysis of the data for types, sources, and skills required for managing conflict. Initial findings identified 46 recommended skills, 206 types of conflict encountered, and 186 sources of conflict. Coding procedures became more refined as the researcher became more familiar with the data. Open coding identified the main concepts, axial coding related the subcategories to the main categories, and selective coding alluded to identification of the *nursing process* as a model for conflict management. A larger sample is necessary to confirm this finding. Continuous data manipulation resulted in the eventual connection of the ten emergent themes of strategies and the relationship of strategy combinations to the use of the *nursing process*.

The typology of conflict management strategies that emerged was compared to those strategies reported in the general literature, and the health literature. This linked established theory with emergent grounded theory (Berg, 1989, p. 120). An analysis of strategies was completed by collapsing the data until a typology emerged (Patton 1990).

The whole process of data collection and data analysis lasted about nine months, with analysis continuing throughout the preparation of the report. Writing the report took approximately four months. See Appendix D for an outline of the data analysis.

DETERMINING RESEARCH TRUSTWORTHINESS AND RIGOR

Qualitative research must be presented in a manner that convinces other researchers of the truthfulness and accuracy of the data

and the analysis. A semantic problem exists among writers who recommend a variety of suggestions of judging research rigor. Guba and Lincoln (1982) consider trustworthiness as comprising credibility, dependability, confirmability, and transferability. For the purpose of establishing this rigor, the suggestions of Guba and Lincoln (1982) and Sandelowski (1986) were followed.

Credibility

Accurate data collection, knowing which data are important, and adequate analysis form the cornerstones of credibility in research. Naturalistic researchers attempt to formulate believable findings from the data (Patton,1990). Credibility is evident when the study describes a human experience so it can be recognized by the participants and other researchers when they encounter it (Sandelowski, 1986). Credibility is ensured by prolonged site engagements, persistent observation, member checks, triangulation, and peer debriefing (Pansegrau, 1983). Familiarity with the field helped establish a comfortable environment for the interviews, and a trusting relationship enhanced openness and accuracy of information. Interviews were held on site and a diary maintained to record observations. Time was not restricted during the interview, but participants were encouraged to discuss their chosen incident until they indicated they were finished. Interview durations ranged from one to two hours. Use of an audiotape made rechecking copious amounts of data possible during the analysis phase, and all interviews were conducted by the researcher. Rich, thick data were collected due to the highly charged stories related by the supervisors,

the intensity with which they were related, and the absence of time restrictions. Transcript verification by the subjects also confirmed credibility.

Member Checking. Participant verification of transcripts and checking interpretations with informants was the process Lincoln and Guba (1985) call member checks. Interview transcripts were sent to each participant once they were transcribed. Informants were frequently surprised at how colloquial speech varies from the written word, though assurances were given that this is the norm. Kirk and Miller (1986) suggest one of the best checks for credibility is the existence of a sensitive researcher who has a good theoretical understanding of the field, and has developed rapport with participants over a long period. The researcher in this study worked in community health nursing, and accordingly attempted to remain objective and not bias the responses. Another check for bias was to have the questionnaire critiqued by two non-nursing professors, and by testing its use in the pilot study.

Triangulation. Including the use of other methods of data collection permits a "rich substantive view of reality", and these combinations "verify many of these elements" (Berg, 1989, p.4). Use of the interviewing technique, having the informants rate a semantic differential attitude scale during the interview, and cross-checking data with field observations and other interviews all contributed to triangulation. The sameness of answers to some interview questions by respondents, and comparison of the responses on the audiotaped interviews of the participants along with the maintenance of detailed chronological field notes also contributed to validity. The data

collection technique of having the supervisors relate skills they believed were necessary to deal with conflict is another example of triangulation. This is known as methodological triangulation, and is used to study multi-dimensional concepts like conflict (Mitchell, 1986).

Peer debriefing. Frequent meetings with the graduate supervisor served to review the research process. A conflict interest group of graduate researchers studying various aspects of conflict served as an external check. Several meetings of this group were held to share material and offer constructive criticism. Presentation of work in progress was jointly presented with the graduate supervisor and a doctoral candidate at the Thirty-fifth Annual Anniversary conference of Educational Administration in Edmonton, AB, in September, 1991; as well as at the American Educational Research Association conference in San Francisco, CA, in April, 1992.

Dependability

Confirmation that the study was dependable, or reliable is evidenced by the triangulation discussed earlier, and by the audit trail.

Audit trail. This decision trail includes how the topic arouses the researcher's interest, and the researcher gives a complete description of the research design and analytical process. A research diary was maintained throughout the study, containing field notes, additional questions, issues, recommendations, and reflections. The diary also maintained dates of meetings, presentations attended,

inspirational thoughts and detailed field notes for cross referencing and thus, provided additional information.

Confirmability

Confirmability, is the criterion of neutrality in qualitative research and is achieved via a combination of auditability, truth value, and applicability (Sandelowski, 1986, p. 33.). Support of the researcher's initial thoughts about the study was evident from the incidents the participants chose, and the emotion displayed by them as details of the incidents were reviewed. Reflective thinking about the issues, and triangulation ensure confirmability. Several participants commented on the cathartic effect revisiting the incidents had for them. This consequence and the occasional strained emotional revelations suggest some form of residual effect of the conflict situation on the participants. Frequent and regular consultation with the peer group of students who were all studying the various aspects of conflict also contributed to confirmability. Triangulation is discussed earlier.

Transferability

Bogdan and Biklin (cited in Hall, 1989) state

> Qualitative researchers tend to view reliability as a fit between what they record as data and what actually occurs in the setting under study, rather than the literal consistency across different observations.

Much information available to nursing supervisors, particularly those in community health settings, comes from other disciplines, or from other sub-specialties of nursing. Transferability has been assumed to date, but will be supported if the same strategies occur in similar situations

of other disciplines, and also between sub-specialties within the discipline of nursing, outside the study situation (Sandelowski, 1986). Checking for fit involves seeing how representative the data are using triangulation methods, including typical and atypical aspects of the data, and having the participants validate the data. The sampling in this study represented typical health centres in the province, and a reflective diary maintained to examine thoughts, ideas, and personal reactions about the data. Thick description of the data was collected which allowed judgements to be made, and allows for interpretation of social expression between people (Berg, 1989).

SUMMARY

This chapter described the methodology used in the study. A description of the method, research design, pilot study, data collection and analysis are presented. The naturalist paradigm encourages the actual observation of respondents dealing with conflict situations, otherwise, the sensitivity of this topic might have threatened the participants or effected unnatural behaviour. Therefore, one would be studying contrived experiences instead of lived experiences. In studying actual conflict encounters in retrospect, the researcher expected open honest reporting of situations rather than contrived experiences; though some of the details may be lost due to the lapse in time. The critical incident approach averts the problem of respondents giving socially acceptable answers to a standard question. The constant comparative strategy of analysis focuses on the development and refinement of theory (Stainback & Stainback, p.41, 1988). Categories

and patterns of strategies were collected and blended to formulate a theory.

The next chapter presents types and sources of conflicts encountered, skills deemed necessary to deal effectively with conflict, and multiple strategies used in conflict management by regional supervisors in community health centres.

CHAPTER FOUR

RESEARCH FINDINGS AND ANALYSIS

INTRODUCTION

The researcher asked regional supervisors to relate a critical incident involving a conflict situation they had found particularly challenging. Interview analysis focused on demographic data, type of conflict, source of conflict, strategies used, skills identified as necessary and a rating of the success of the strategies by the regional supervisors. The primary emphasis of this research was to identify strategies used by the regional supervisors. This chapter will present the findings of the data analysis. Constant comparative analysis of the data resulted in data collapse to ascertain if a typology of strategies would emerge. This aspect of grounded theory resulted in the identification of a typology that emerged in this study.

CONFLICT PARTICIPANTS

The researcher interviewed eight regional supervisors; five from urban settings, and three from rural settings. Formal educational preparation of these eight varied; one had completed a diploma, four had completed baccalaureate degrees, and three had completed master's degrees. Three of the baccalaureate prepared supervisors were considering further studies at the master's level. The years of supervisory experience ranged from three to eighteen years, and four of the eight had taken special conflict management courses. None of these

courses were part of their educational programs, but taken as staff development or as personal interest workshops. These findings are summarized in Table 3.

Table 3: Background Information of Regional Supervisors

Participant Number	1	2	3	4	5	6	7	8
years supervisory experience	5	6	11	9	5	3	18	11
education R.N. diploma (1) bachelors(2) masters(3)	2	1	3	3	2	3	2	2
urban (1)	1	0	1	1	1	1	0	0
rural (2)	0	2	0	0	0	0	2	2
orientation y(1) n(2)	2	1	1	1	1	1	1	2
Likert scale	3	4	3	5	5	3	4	4
institutional support y(1) n(2)	2	1	1	1	2	2	1	1
special c. m. courses y(1) n(2)	2	1	2	1	2	2	1	1
notable personal effects y(1) n(2)	1	2	1	1	2	1	1	1
staff morale adversely affected by budget cuts y(1) n(2)	1	2	1	1	1	1	2	2

In seven cases, the primary conflictuants were community health staff nurses and administrators, and the remaining case was with a client. Three situations expanded to encompass other administrative staff, and in two instances the conflict grew to include upper management.

TYPES OF CONFLICT

Examination of the data using an emergent approach indicated a variance in types of conflict reported in community health centres. Types identified according to frequency were: affective (68%), internal (58%), interpersonal (42%), external (36%), and task oriented (30%).

Affective

An example of affective conflict which influenced feeling included dealing with a post-strike situation when strikers and "scabs" were working together. Another instance was when one clinic absorbed several staff from another clinic during a building renovation. Interpersonal problems between staff members, differences in values between a regional supervisor and some of her staff, and ethical complications involving confidentiality and beneficence frequently resulted in affective types of conflicts encountered. A health centre closure distressed the entire staff in that area. Several supervisors expressed a feeling of betrayal regarding government's declared commitment to community health versus the actual practice of budget reductions.

Internal

Organizational structure and processes were at the heart of internal types of conflict. Internal conflict occurred with incorrect use of established communication channels, staff layoffs, and role overload. Perceived lack of support from upper management and interstaff coalitions also contributed to internal conflicts.

Interpersonal

Interpersonal conflicts are situations involving differences in opinion or clashing personalities encountered in the work setting. One

situation with interpersonal conflict occurred when a new manager arrived who had a different style than the previous one. Another interpersonal conflict arose with the collision of differing philosophies of nursing practice between the supervisor and a staff nurse. Staff reluctance to follow established guidelines for practise resulted in interpersonal problems in two clinics, and resistance to change occurred in three clinics. A confrontation with a client arose in one clinic.

External

This category includes conflicts associated with budget cuts, the rural phenomenon of working in a small community, externally dictated programming changes, hiring freezes, and strikes.

Task oriented

Task related or substantive (Loewen,1983) conflicts involved such things as: clinic cancellations, program delivery, strikes, layoffs, organizational transition, and simply organizational maintenance.

Combinations of types occurred frequently. Typically, *affective internal interpersonal* disagreements were the main issues to be dealt with, and sources of the conflicts varied, as the examples used to illustrate types of conflict indicate.

SOURCES OF CONFLICT

Sources of conflict can be described as the place, person, situation or statement that leads to opposition, struggle, or disagreement (Avis, Drysdale, Gregg, & Scargill, 1973). In community health centres the sources of conflict that emerged, in order of

frequency, were as follows: interests (58%), roles (46%), personalities (42%), goals (36%), values (33%), regulations (32%), tasks (32%), and resources (24%).

Interests

This category comprises issues of personal interests affecting participants; feelings of curiosity or benefits, or taking part in an activity that affects the individual such as being compromised because of impending strikes, territoriality, physical renovations, interpersonal problems, ethical issues, jealousy, lack of trust, unhappy clients, differing philosophies, little support from upper management, inconsideration, conflict of values, feelings of betrayal, staff cuts, coalition formation, manipulative behaviour, and a hierarchical organization.

Roles

Role conflicts occurred when the part an individual played in an organization was changed or otherwise affected by such things as an impending strike, territoriality, ethical complications, staff problems, role overload, differing philosophies, accountability, team support, resistance to change, staff cuts, budget cuts, little support from upper management, hierarchical decision making, and organizational maintenance.

Personalities

This type of conflict was rooted in the qualities of individuals that make them unique persons, such as tendencies toward jealousy, lack of trust, and rule avoidance.

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Resources

This grouping refers to the supply of anything that meets a need such as staff, versatility and actual budgetary allocations at the health centre level. Budgets are related to staff relocations, strikes, physical renovations, clinic closures, layoffs, role overload, programming, organizational transition, and frozen positions. Resources are frequently cited as the initiator of conflict situations.

One regional supervisor, who reported a current conflict situation, stated that the actual source of the conflict was unknown at the time of the interview.

SKILLS DEEMED NECESSARY

The regional supervisors alluded to skills forty-six times. These skills were subsequently categorized into 12 groups:

Flexibility - and the ability to present an alternate viewpoint; to see options

Analytical - to think strategically, postpone judgement, stand back, and give yourself time to think and not act too hastily

Accepting - acknowledging; being fair, know your biases, being objective, understanding, and knowing when third party help is needed

Availability - time management, and being there when needed

Proactive - planning ahead, generating respect, and practising participative management, and being in prevention mode

Thick skinned - working well under stress, iron gut, being God

Facilitate - knowing when to lead, defining your expectations, taking control when necessary, willing to effect change, positive attitude

Thorough Assessment - gather information, get all the facts, look at information from different viewpoints, ask questions

Communication - listening, sharing, showdown when necessary

Honesty - displaying fidelity and sincerity; and the ethical principal of veracity

Integrity - solid belief system, sincerity in management style and a sound value system, modelling desirable behaviour.

The participants were very interested and intrigued by the exercise of reflecting on skills they felt to be necessary to effectively function as a supervisor, particularly with respect to conflict management. Some interviewees recommended "a course of some sort" for developing these skills.

Recommendations for additional course work in conflict management in nursing curricula were made by six of the eight supervisors. Proposals for additional support from upper management - in the form of workshops, staff development programs, and conferences - were additional suggestions offered. Recognition of experience in the field and peer group support also must be mentioned as common sources of skill development and assistance. Assertiveness in being able to know when to ask for help is an identified area that requires development.

STRATEGIES USED

As a means of understanding the complex phenomenon of conflict, the major emphasis of this study focuses on strategies - "What to do?"

Two hundred eighty-five strategies were described and allocated first to 107 categories; then to 38; and eventually to 10. These broad categories represent the composition of the many strategies identified into recognizable groups and are summarized in Table 4.

Table 4: Emergent Strategies

PRIMARY STRATEGY	SUBSTRATEGY	INCIDENCE
Manage knowledge	Acquisition Dissemination Request assistance Assessment Advocating values Affect	48
Tackle the issues	Confrontation Hit and run Counselling Warning Use of power Organizational function Provide space with the boss	22
Demonstrate Affect and Values	Demonstrate empathy Acknowledging anger Rescuing Values orientation Professionalism	18
Anticipate	Proactive behaviour Use of models	18
Pause and Ponder	Strategic waiting Reframing Interpreting Retrospection	16
Control	Environmental control Smoothing Organizational parameters Limiting coalitions Returning problem to originator	17
Defuse the Situation	Accommodating Initiating action Protective Covering rear	10
Use Logical Consequence	Maintaining neutrality Returning problems to complainant Giving people enough rope	7
Nurture Coalitions and Cooperation	Cooperative approach Mediation Combine forces for common cause	12
Dodge	Avoidance Denial Artful dodger	5

MANAGE KNOWLEDGE - This includes the acquisition and dissemination of information via listening, confirming, requesting assistance, assessing, giving advice, withholding information, keeping current, sharing info, sharing decision making, seeking approval, encouraging approval, encouraging new ideas, and a sense of timing .

One situation related concerned staff dissatisfaction with a new manager. A small group went to the director with their concerns without informing the manager there was an apparent problem. A statement on principals and values had been developed prior to this, which addressed issues of integrity, trust, valuing people, confidentiality, and communication channels. The supervisor felt there were ethical issues and policy issues to deal with.

We'll be redoing our goals and objectives, and values and principles and stuff this year. I don't think they are going to change that much. One thing about them which should have addressed this is that they are addressed too much for within the organization, and not enough for without, telling the community. They are going to be written so there 's kind of within and without.
...a year and a half ago we had developed principles and values in the health unit of the management team, and they had been circulated out to the staff, and they were asked for their input, and then they had come back and were approved by the board. They were then put in the front of the policy manual.
. . .there were ethical complications here, too; so we decided to phone the AARN about it. . . .our orientation program has to be corrected.

A health unit was faced with a possible strike that was averted, but left a lot of division among staff. Around the same time job cutbacks were initiated due to budget concerns. Distinctive camps evolved with obvious hostility between them. Interpersonal relations suffered, and the health centre routine disrupted.

I decided to reframe the staff's behaviour as a grieving, so I wrote them all a letter saying . . .I had a need to see us moving onward and looking at growth and rebuilding. As part of that process I wanted to understand what their workload was, so that I could evaluate the stress the stress of the workload and start there. I compiled a very detailed report that I asked them without choice to fill out on a weekly basis. It was very interesting information for me. What I did with the information is that I compiled it, and I gave it back to them, and if their information didn't come in it didn't look like they did as much.

Another supervisor was faced with the repercussions of a long strike, with resultant interpersonal difficulties.

I read tons of books on conflict and problem solving; I needed to develop my knowledge and skills in that area before they came back.

TACKLE THE ISSUES - This cluster includes actions that result in confronting the issue, or engineering a showdown to clearly focus on it directly. This group includes reducing pressure, accepting, counselling, warning, constructively using power, challenging, refusing to be manipulated, maintaining organizational functioning, stating expectations, defending oneself, or providing space with the boss.

The case of the staff member who was not working up to job expectations.

Next year I think your position will be cut back to 2 1/2 days, and if you don't think you can do your work come and discuss it with me. She wrote me a letter and said, "I can't possibly do my job in that length of time, and if you won't do something, I'll resign." And I wrote her a letter and thanked her for her resignation.

Staff divisiveness in a clinic setting.

I've arranged for a meeting with teambuilding consultants, the director, and the staff. I want a solution to some of the programming that my group are not doing.

Interdisciplinary dissatisfaction with a job appointment; staff from all the centres' service areas were represented. A large group attended a meeting with the supervisor to vent their unhappiness with her choice. The meeting took on very negative tones, in spite of the presence of a close relative of the incumbent.

I stopped the meeting and I said to her, "Do you want to leave?" When you're working through a confronta

I have been on her case regularly, every time I see her manner become unprofessional at the front desk, or a confrontation with another staff, I call her in right away. I'm on her case constantly.

DEMONSTRATE AFFECT AND VALUES - This category addresses the feeling level in terms of being empathetic and acknowledging anger and the varied responses surrounding situations. This category includes sharing feelings, controlling anger, being fair, rescuing, listening, looking for positive outcomes, working from a values base, and maintaining integrity and professionalism.

A difference in philosophical professional beliefs led to interpersonal strife between a supervisor and a staff nurse. Serious concerns arose over clinic operations as other staff were drawn into the fray.

My belief system is to be an administrator from a principled practice; and I look at principles of fairness, equity, honesty, and integrity. My expectation is that my staff will work from that kind of base. I sense that people have different kinds of values. Some value promptness and adherence to policies and procedures; others value independence, innovation, and evolution of their own nursing practice. Somehow, these two have to be pulled together, because I don't think they can function independently of each other.

Due to a health centre closure, several staff members transferred to another centre.

Trying to think of ways that we might make that staff feel more welcome, and to offer moral support. I tried to be here. I didn't really tend to the things that I needed to do, my first objective was that the staff had what they needed to get their job done day by day. A sense of "it's going to get better". The other thing I tried to do was to be absolutely honest with the staff and give them as much information as I could.

The situation referred to earlier when staff vented their negative feelings irregardless of the presence of a relative.

I don't think they knew that I was angry.
I could identify with that because I wanted to become the rescuer. I wanted to be sure that she was on the same playing field as the staff so she wasn't at a disadvantage.

> If you have integrity, you are not going to allow gross incompetencies to exist, but you go through the proper ways of reporting it. "
> I think I've done what I can, to this point, and I feel positive that I haven't allowed the staff to push me into making decisions and judgements that were unfair, or distorted, or whatever.
> I, we have worked hard, I felt, to be a good employer. To make the health unit a good place to work, to have good job descriptions, to have some values and principles to give people guidelines so they know what's expected of them.

ANTICIPATE - Preventive actions and proactive measures comprise this grouping. It includes such things as planning, seeking support, saving face, encouraging respect via positive role modelling, cultivating liaisons, and using a model such as the *nursing process* in conflict management. Prophylactic measures such as these have a protective dimension for a staff and ultimately for the clients.

> *A community request for programming arose that budget restrictions would not permit.*
>
> There's good things that come from conflict. The reality hit and we couldn't expand in that area again unless we started using some outside resources. What's happened here is a Seniors' Wellness program. Seniors are involved in planning programs for seniors. I can't imagine that we haven't done this years ago.
>
> *Interpersonal strife between a new, inexperienced staff member, and three long term staff.*
>
> In retrospect, the only thing that I would have done differently, and this is to prevent problems...I remember when I hired this nurse. The interviews were very close. There was a young nurse, also without as much experience. You weigh, and how do you decide who to hire. I can remember my gut feeling saying, "Maybe I should go with this younger nurse". I think that's always very important when you're hiring, you think of your existing staff, and how is a new person going to fit.
>
> *A new supervisor began to understand there was something that needed to improve in the setting, but was unsure of the source of the conflict.*
>
> We have had two total inservices, and we just completed the second one, at which point we introduced the concept of theme teams, and quality improvement teams. I see (working with a model) as a process that is going to have to happen. The first thing will be

trying this individual thing, because they are not together; and I need to come forth with some solutions.

Staff nurses were unhappy with the new organizational structuring proposed by a new supervisor, and collectively complained to another supervisor.

When it was somebody in a managers' position being complained about, I could identify with that because I wanted to become the rescuer. It was much better to let her solve the problem knowing she had support if she needed it.

PAUSE AND PONDER - This strategy is defined as strategic waiting combined with reflecting on the issue. Items in this category are waiting, allotting time for staff, adopting an attitude of "This too shall pass", reframing or using a paradigm shift, interpreting, and utilizing retrospection.

A health centre was closed due to budget concerns. Staff were initially very disappointed and distraught.

We had time to talk about it and had some time for grieving. This too shall pass; but it's one of those things I don't think it in anyone's power to change. I think it's really interesting when you get into conflict, it's not blaming. There's nothing to be gained by blaming, you have to look at why it's happened, and what you can do so it won't happen again, and so that people can learn from it. Eventually the staff moved and from what I hear, have adapted very well to the new settings. They needed time.

A highly stressed young mother became very angry and disruptive at a well baby clinic when she felt she had waited too long to be seen.

It turned around. I guess what I'm saying, is, sometimes you're caught in a situation, and you have to think fast, and sometimes your reactions, or not having enough information, or various factors prevented a good outcome initially. Everything does not have to be lost. We all do make mistakes. You can still salvage things, you can still improve relations if you're willing to sometimes humble yourselves a bit, open your ears, and listen. That evening I tried to think about it from her perspective, not just mine, which is " people are late, staff are overworked, and everybody is running."

An interpersonal conflict between two staff resulted in verbal attacks on each others' professional abilities. Other staff were becoming involved.

One thing I have realized over time, is that sometimes you can act too hastily, and yes, time was the healer.
I still wasn't pushy; assertive with that until about six months after. In retrospect, I would have had those meetings with those two, and set up a work plan earlier than I did. It did work, but it got pretty bad.
The thing that I am most consistent with, is to try and identify what the problem is before getting to solutions.

CONTROL - The authoritative approach is seen in actions to control the environment, smooth, maintain objectivity, direct behaviour, set and enforce organizational parameters, be ruthless, and limit the formation of coalitions. For example:

Reinstatement of full time clinic operation after a long difficult strike.

I didn't allow camps to form in the work immunization teams and stuff like that. I wouldn't let all the "scabs", or all of the other group have their teams. I would structure so that there had to be some overlap always.

Two nurses were assigned to the same specialty area and impending budget cuts were looming which meant one person might be shifted to another area. One staff was very threatened about this, as she felt she was very competent in the area, but had less seniority. It resulted in a tense environment, with one nurse downgrading the other at every opportunity.

I would have to do something ruthless to change it; I may have to re-evaluate this area completely, but they are both good nurses. Being a little more dictatorial about it. I expect either a solution, or it not to affect work.

DEFUSE THE SITUATION - This grouping of strategies, often described as accommodating behaviour, is seen in rearranging staffing, taking the first step after an incident, being protective of certain staff members, using the *nursing process* to develop action plans, and of course, covering one's bases.

Opening of a new clinic with limited resources, and unfamiliar staff.

A couple of other things that helped were that I did any kind of job that needed to be done during that time. I spent lots of time answering the phone, if that's where the stress was that day. I think the ability to think of the whole situation and where the problems lie, and just pitch in and help.
I tried to be here.

Trying to establish an accommodating climate following a strike.

As they came back, I individually went and spoke to each person. I made a point of it, "Welcome back! I'm glad you're back!" That sort of thing. Then what I did, was I took all of the nurses that were there already, and I took them around to each nurse individually, and introduced them. I acknowledged that this might seem tense and uncomfortable, but we're all working from this office, and so this is who these people are. Just made a point of going around and introducing everybody. We worked out a little action plan with each, what they were going to do, what I was going to do.

USE LOGICAL CONSEQUENCE - This term is often used in relation to parenting skills, but as one respondent so aptly phrased it, "Much of what I do in conflict situations I learned through parenting; those skills are transferable." The staff must take responsibility for their own actions and realize they have the ability to resolve many issues. Judicial withdrawal on the part of the supervisor allows a logical sequence of events to take place. The technique for the supervisor is to NOT impose demands but to let the natural consequences motivate behavioral change. Examples include returning problems (like time management) back to the complainant, or carrying on with announced plans even though total compliance has not been achieved (this may result in some staff members being omitted from activities or reports). Some examples:

The case of community nurses wanting to visit clients while hospitalized, or attend funerals during work hours.

Let them take responsibility for their own actions, and the outcomes.
" That's fine, if you want to go see patients after work, or whatever, but if you're so busy, how do you have time? You solve it. If you can't cope with that, that's your problem."

Interpersonal difficulties between staff members.

. . . we both knew the best thing was for them to resolve their own problem.
Some things that are very simple and straightforward, I wouldn't even become involved in, I'd just say "You go and talk to them about it, and if you can't resolve it, bring it back again.

Staff member upset about a report of work allocation in which it appeared she had not been maintaining the status quo.

" How can that be reflective? I didn't give you my data." I said, "I'm very aware of that. I worked on the data that I was given, so if you didn't get the benefit of what you did not submit, I cannot be accountable for that." The post reports came in quite quickly!

NURTURE COALITIONS AND COOPERATION - The cooperative approach is used to strengthen one's stand as a supervisor, working with staff, acting as a mediator, including all staff, and having opposing groups combine forces to deal with a common issue.

Dealing with staff unrest after clinic reorganization.

. . . if you're a democratic organization and the majority say this is how it should work, ...I went with the democratic decision I phoned right away down to the main office, and I said," I don't know what I'm going to do!"

Supervisor concerned about professional liability.

. . .So, we decided to phone the AARN about it.
I much prefer to work on a cooperative basis. . .

Adapting to changing perspectives of health care, as staff voice their concerns regarding job description and job security.

Everything is in cooperation now, with schools, service agencies, you have to know who your staff are working with day to day. You have to form some liaisons and relationships with these groups, and sometimes it's hard because you're coming from different perspectives. People don't have time for more meetings, but you still need them. I think if we ignore this, we're going to get

> left behind in the rush these days. Learning to work with other disciplines is very hard, because they don't think like I do. It's a challenge.

DODGE - This class of action is frequently referred to in the literature as avoidance, denial of an existing problem, encouraging a solution at the wrong level, refusal to participate in head-on situations, and not checking up on identified issues. The "artful dodger" averts, escapes, abstains, refrains, and is the master of the "lateral arabesque" (Ward, K., 1992; personal communication).

> After thinking about it and getting some outside input, it was much better to let her solve the problem knowing that she had support if she needed it.
> It might be. I sometimes think in a management position, you can be conned, you can be set up. If I think I'm in an "I gotcha!" game, I just check out, I won't play. So it's not really buying time, it's saying " It's not important to me. I don't want to have anything to do with it. You solve it.
>
> *Supervisor reflecting on expectations for program delivery change which a staff member was refusing to accept.*
>
> I think the other part was that it's been nine months now, and nothing has happened, so I guess I had better do something about this.
> I still wasn't real pushy; assertive with that until about six months after.

Combinations of the strategies have also been identified: such as the "Hit and Run" technique, which uses *tackle the issues*, *control*, *and dodge*. This is the strategy that sees a person, one who usually has more power than the recipient, delivering an accusatory message, then exiting and refusing to stay and discuss it any further.

PERCEIVED SUCCESS OF STRATEGIES - A semantic differential scale was rated by the respondents to indicate where they ranked the success of the conflict management strategies they used. The scale ranged from

"highly positive" (5) to "highly negative" (1). The respondents' self-ratings ranged from 3 to 5. Three respondents rated the strategy success at 3, three at 4, and two at 5.

Personal strategies used by the regional supervisors to cope with the effects of conflict management in their jobs are of interest. Some of these strategies were adopted temporarily, for the duration of a particular situation, and others as regular pastimes. They included skiing, jogging, taking part in a peer support group for the duration of the conflict situation, reading, attending workshops, and spousal support. Several of the supervisors interviewed commented on the cathartic effect of describing these sensitive and sometimes painful situations.

SUMMARY

Data collapsed to a final identification of general themes for the areas examined to: 12 requisite skills; 5 types of conflict; and 8 sources of conflict. The major focus of this research was identification of the conflict management strategies used by regional supervisors of community health centres. The participants also revealed 10 themes depicted in Table 5 below.

The main story line appeared to be focused on the supervisors' combined use of strategies which related to the *nursing process* as a conceptual model to taylor strategies to each incident. Most often supervisors used only one strategy, but sometimes combinations of strategies appeared, e.g., the "hit and run" combination mentioned earlier. See Appendix E for a description of the *nursing process*.

Examination of the areas of types, sources, skills, and strategies described only a portion of the events related. The data also indicated that the supervisors operated from a values perspective when facing the challenge of conflict management. The essential phases of elements of a conflict episode are: A) Sources of conflict, *(assessment)* lead to B) Typing of conflict, *(diagnosis)* which leads to C) Skill development attempts, *(planning)* which leads to D) conflict management strategies, *(implementation)* which leads to E) Effects of strategies *(evaluation)*. These steps clearly follow the established pattern of the *nursing process;* with a reminder that the model is a simplification of a complex, circular, and humanistic process.

Table 5: Categories of Conflict

TYPES:	SOURCES:	SKILLS:	STRATEGIES:
Affective	Interests	Flexibility	Manage knowledge
Internal	Roles	Analytical	Tackle the issue
Interpersonal	Personalities	Accepting	Demonstrate affect and values
External	Goals	Availability	Anticipate
Task oriented	Values	Proactive	Pause and ponder
	Regulations	Thick skinned	Control
	Tasks	Facilitate	Defuse the situation
	Resources	Assess	Logical consequence
		Communication	Nurture coalitions and cooperation
		Honesty	
		Integrity	

CHAPTER FIVE

DISCUSSION OF FINDINGS

INTRODUCTION

This chapter presents an overview of the study design and a summary of the findings, then moves to the conclusions and discussion. The chapter concludes with implications this study has for further research, development and testing of theory, and practice in community health nursing administration.

OVERVIEW OF THE STUDY: PURPOSE, METHODOLOGY, AND DESIGN

Purpose of the study. This study investigated how regional supervisors of community health centres manage conflicts they encounter in the clinical area. The specific research question addressed in this study was:

> What conflict management strategies are employed by community health nursing regional supervisors in a western Canadian province?

Subquestions which guided the research were:

1. How do supervisors rate the success of the strategies used?
2. What are the types and sources of conflict regional supervisors encounter?
3. How do supervisors' values affect the strategies they use in managing significant conflict situations?
4. Do regional supervisors receive adequate preparation to manage conflict at an educational level and/or via professional development?
5. Do regional supervisors have adequate support systems in place within the organization?

6. How do individuals deal with the resultant stress of conflict management on a personal level?

Research Methodology and Design. A descriptive exploratory study, designed under the umbrella of the naturalist paradigm, described the role of other participants in the conflict situation, the type of conflict, source of conflict, and the conflict management strategies used by the regional supervisors, which was the main emphasis of the study. It also included the supervisor's rating of the success of the strategies used in each particular situation, and a description of the skills they recommended to manage conflict.

Interviews were used to collect the data from supervisors in urban and rural settings of a western Canadian province over a five month period. The researcher conducted ten formal interviews, two of which served as a pilot study. The stories and lived experiences of the regional supervisors interviewed were the major source of research data. The interviews were taped, transcribed, and returned to the participants for verification. Maintenance of a reflective diary to record setting descriptions, contributing information, personal thoughts and questions, and to review the findings helped to trace the issues which emerged from the data. The constant comparative method of analysis in grounded theory was the method of choice to determine the typology of strategies that emerged during the research. Two hundred eighty-five strategies for conflict management were identified, and reduced to one hundred eight, then finally ten categories. Types of conflicts reduced to seven categories, sources to eight categories, and skills to twelve

categories. The findings confirmed those reported in the literature, both in health and non-health related disciplines.

SUMMARY OF THE FINDINGS.

Research question.

What conflict management strategies are employed by community health nursing regional supervisors in a western Canadian province?

Ten categories of strategies of conflict management emerged.

Strategies:

1. Manage knowledge
2. Tackle the issues
3. Demonstrate empathy
4. Anticipate
5. Pause and ponder
6. Control
7. Defuse the situation
8. Logical consequence
9. Nurture coalitions and cooperation
10. Dodge

This study showed which conflict management strategies regional supervisors use to assist those involved in finding solutions, and often look to a variety of approaches to management. The most frequent tactic was that of managing information, or knowledge, with the confrontational tactic of tackling the issues following. This group of managers all demonstrated empathy towards the conflict participants, which could be related to the altruistic nature of this professional group. Anticipating conflict and taking proactive measures of management was the next strategy noted in order of occurrence. The technique of pause and ponder, or waiting before impulsively rushing to the rescue, was advocated by several supervisors, particulary those with the longest length of service in supervisory positions. This might possibly be attributed to the 'wisdom of experience' gleaned by these practitioners. The final decision

rests with the supervisor, and effective use of power and control is often evident. Defusing the situation is another frequently used strategy, and is often described as accommodative behaviour with stakeholders relenting slightly to appease the situation. This strategy is often used to buy time but requires that the situation be addressed again at a later date. Logical consequence, or letting a situation run its course with participants affected by the results (within reasonable parameters) is the strategy one participant likened to parenting skills. The collaborative approach of nurturing coalitions and encouraging cooperation commonly occurred with this group of managers, as well as the avoidance technique of dodging the issue. This category was also reported by Wolcott (1983) and Gibson (1986).

Subquestions.

1. How do supervisors rate the success of the strategies used?

The supervisors rated the success of the strategies they used on a five point scale with high being very successful, and low being unsuccessful. The scores ranged from three to five, in spite of the fact that two situations were underway at the time. This may indicate that further reflection on the situations by the supervisors confirmed the appropriateness of their choices, with the three choosing the midway point as somewhat undecided.

2. What are the types and sources of conflict regional supervisors encounter, and what requisite skills do they recommend?

Types: Pondy, cited in Owens (1987) describes three types of conflict; competition for resources, autonomy (protecting one's turf), and goal divergence. This research provides evidence of all three in terms of budget restraint, changing organizational structure, and altered priorities of

provincial health. Types of conflict encountered were similar to those reported in the literature, with five types noted. Affective included value based issues, ethical issues, territoriality, and the emotional reaction of participants to situations. Internal types described would suggest that upper management could offer more visible support to middle management as well as noting the existence of role overload with suggested coping mechanisms. Interpersonal types will always exist where you have more than one person working, reinforcing the well known benefits of fostering communication skills among staff. External types can be very difficult to deal with as they are often completely out of the control of the supervisor, thus leaving her to feel she is somewhat powerless. Task related types of conflict are likely the least complicated to manage if they remain unlayered with other types. The layering or combinations of types mentioned in chapter four referred to the example of "hit and run." Another illustration of layering is "giving people enough rope to hang themselves with," which encompasses the strategies of managing knowledge, pause and ponder, control, and the use of logical consequence. This can actually provide a growth experience for staff, but can easily turn into a conflict with the bypassing of supervisory alliance, and tends to complicate matters. The literature does not report specifically on combinations of strategies, often referring more to the effects of overlapping conflicts.

Sources: Eight categories of sources of conflict were presented in chapter four, and health centre supervisors readily share that few conflicts arise from only one source, but occur in combinations with other sources.

3. How do supervisors' values affect the strategies they use in managing significant conflict situations?

Values operationalize community health clinics and set the foundation of community health standards and operations. Francis and Woodcock (1990) write of organizational values:

> A value is a belief in action. It is a choice about good or bad, important or unimportant. Values in organizations are mainly established and maintained by leaders. Values shape behaviour. Until a value is acted upon it remains an inspiration. Management is based on a mature insight of what is, not an idealistic concept of what might be.

They identify seven stages of management values development (p. 5-13):

rationality - scientific analysis pays

emotionality - care for people pays

confrontation - strong defense is vital

consensus - politics matters

organizations/ individual balance - performance is king

potential - people can develop

realism - nothing good comes easy

All regional supervisors in this study operated from a well developed values orientation as described by these authors.
The supervisors based managerial decisions upon moral codes and personal and cultural values, thereby reflecting an ethical dimension. Conflicting values such as theoretical guidelines versus organizational rules and site level considerations can lead to ethical dilemmas (Brieschke, 1988). Self interest, social values, organizational and professional values were the criteria identified as important for managing ethical dilemmas, and a manager's actions are dependent upon their perception of and experience in the organization. It could be stated that the managers in this study were likely to adhere to

established ethical organizational norms as reflected by their decisions, indicating supervisor motivation based on values.

4. Do regional supervisors receive adequate preparation to manage conflict through formal education and/or via professional development?

The findings reported in chapter four indicate the variance in educational preparation of nurse administrators in this group of regional supervisors. Stinson (in Henry, Hayden and Richardson, 1989), clearly advocates that nursing administration maintain Canadian Nursing Association standards, continue research and support advanced educational levels to support this initiative, and to develop, test and integrate nursing administration theory. Several of the supervisors interviewed actively pursue advanced skills in conflict management by reading and attending relevant workshops as they are available. Many recommended agency sponsored workshops that would deal specifically with conflict management. This information suggests that educational programs and professional development should address conflict management at a more rigorous level than what currently exists.

5. Do regional supervisors have adequate support systems in place within the organization?

Several supervisors indicated they often felt alone in dealing with conflict situations, sometimes seeking support from other disciplines sharing office space, upper management, or from peers. A common statement made by the supervisors related to not wishing to burden others with problems as they were aware that each person had her own set of issues to contend with, a statement not referred to in the literature. Some felt they received excellent support from within the organization, while others did not.

6. How do individuals deal with the resultant stress of conflict management on a personal level?

Stress management includes not only relaxation techniques, but encompasses the individual's resources, values, needs and priorities and time management (Fortin, 1992). The participants reported personal responses to stress associated with conflict management took the form of exercise, eating, seeking spousal/friend support, and shopping. They also noted that strain at work transferred readily to the area of significant relationships, with both positive and negative effects reported. Balancing emotions with reason is necessary for rational decision-making (Fischer and Brown, 1988).

Role overload as described by Ward and Price (1991) was commonly experienced by the supervisors in this study.

CONCLUSIONS

The interpretation of the findings and suggestions of ways which discreet findings may be linked or related follows. That is to introduce or suggest a theory, which the Gage dictionary defines as 'the principles or methods of a science or art.' The models described in the general and health related literature encompass the strategies identified, and choice of strategies chosen depends upon the individuals involved and the situations. The constant comparative analysis identified the use of the *nursing process* as a model in conflict management (see Appendix E for details of the *nursing process*). Previous information indicates that managers often use some form of model to address conflict, and nursing literature is just beginning to report the adaptation of the *nursing process* to conflict management (Strader in Decker and Sullivan, 1992; Kelley in Ward and Price, 1991; deBono, 1985;

Thomas, 1976; Araki, 1983,; Noble, 1991; Saulo, 1987; Okolo, 1985; Gibson, 1986 and Jones, 1990). The use of "layering" or combinations of strategies by the regional supervisors in this study echoes the elements of the *nursing process.*

The three strategy models described by Chaffee (1985); linear, adaptive and interpretive, are implemented by the regional supervisors. Collectively, the linear strategy of adopting a blueprint for action for the future and the interpretive strategy of stressing motivational intentions both receive attention, yet the main concentration seems to be directed towards the adaptive strategy. Proactive and reactive responses take precedence, and matching community needs with health centre care parameters requires risk, adaptability and the ability to conceptualize interdisciplinary goals. Strategies identified in the review of the literature were numerous, and of the twenty strategies described in the general and health related literature, evidence of the use of all of them was provided by the regional supervisors. The strategies that received no mention were denigration, firing (excisionistic fallacy), and self aggrandizement. The humanistic approach was strongly advocated, supporting Wirt (1990) in his advocacy of this method. A prodigious emphasis on the affective domain was apparent with the nurse supervisors.

Suppression of conflict can result in aggravated explosions which Owens (1987) describes as "conflict aftermath." This was evident in two of the situations described in this study, and the conflicts remain unsolved at the time of writing, which supports Owens' contingency view that there is not one best way of managing conflict, but certain conditions can lead to optimal

management techniques. Contingency theory must exist in this climate of rapid change, evolution, and environmental change.

Regional supervisors live with conflict and expect conflict to occur in the clinic situation and in the life of the community it serves. The strategies chosen by the regional supervisors were dependent upon the situation, the individuals involved, and the particular style of the manager, and were appropriate to the organization. The regional supervisors were able to adapt strategies to the unique variables in each situation, such as individual personalities, time frame, and extent of the conflict in the organization; plus operate from a values basis, which Evans (1991) and Lynch and Tieje (1991) recommend.

The use of the constant comparative method proved to be an appropriate technique for advancing the study of conflict in community health settings, and clearly demonstrated how themes can emerge from the data. The sample size of the group studied was small, and therefore may not be representative of all regional supervisors in this field. Further studies of conflict management using the complete or modified method of grounded theory are recommended. Glaser and Strauss (1967) write that this method has the researcher start with raw data and finish with a substantive theory in the area researched. They feel a substantive theory:

> . . . can give participants in a situation a broader guide to what they already tend to do, and perhaps help them to be more effective in doing it (p.248).

These data do not allow the development of substantive theory, but identify factors which may lead to theory development in this area. The hope is that the evolving theory can be interpreted by regional supervisors as applicable to their situations, and that the categories of conflict management strategies

can be applied to the development of principles and methods specific to the art and science of conflict management in community health nursing.

IMPLICATIONS FOR FURTHER RESEARCH

The findings of this study parallels previous research as reported in the general literature as well as in health related literature. A greater emphasis is currently being placed on the qualitative approach to study conflict in several health disciplines, particularly nursing. In addition, nursing management texts are beginning to address conflict as a significant area of study. It is clear that additional research must be done in this area to expand the knowledge of theory and practice, and to determine the uniqueness of nursing managers' approaches to conflict management. Verification of the categories that emerged can be obtained through additional research. Hawkins and Prout (1990) and Saulo (1987) recommend incorporation of topics reflecting role components into nursing curricula, and conflict management is one topic ranked as high priority. They feel that students should be taught that conflict management requires a positive sense of self, assertiveness, problem solving ability, decision making, empathy, and that they should focus on issues and behaviours rather than persons. Students should be taught economic, political, societal, and professional forces affecting nursing. Emphasis placed on political skills plus managerial and interpersonal skills will assist them in appropriate choice of strategies (Eason, Spickerman, and Lee, 1990). Nurses must become members of the political circles that are the ultimate decision makers (Growe, 1991). Stinson, in Henry et al. (1989 p.115 - 118), advances the case for additional education of nurse administrators, but she states it must be much broader than

" a collage of nursing and management courses," advocating interdisciplinary approaches to topics and relating them to nursing. Management courses should be taught by experienced nurse administrators with an integration of management and nursing content, being careful to prepare nursing care service managers rather than management scientists. The method of combining systems theory with the *nursing process* as a conflict management model might be explored.

More research is also necessary to determine the ways individual values affect decisions. Models of administrative practice often omit a value dimension, either assuming standards implementation, or ignoring their significance. This study supports the statements of Hodgkinson (cited in Kasten and Ashbaugh, 1991, p.54) as he writes of "the ever increasing recognition that administration is fundamentally a value-laden, even value saturated enterprise." Further study of the values of supervisors will lead to expanded knowledge on the "nature of administration," and form the basis of decision making and organizational culture (Kasten and Ashbaugh).

The mention of the issue of gender response to conflict occurred occasionally. Children, especially females, are taught that conflict is destructive and negative, but Deutsch, cited in Gibson, 1986, says conflict is not necessarily destructive or lacking in pleasure, but can help revitalize existent norms. Lacey (cited in Gibson, 1986) found that women tend to be more trustworthy during initial interactions, but are less willing to forgive a violated trust. Women lack alternate styles of manipulating difficult professional encounters. Miller, cited in Mason, Costello-Nikitas, Scanlan,& Magnuson (1990), notes that many women are not comfortable with power grabbing, but are more comfortable with power sharing. Chodorow (1978) and

Donovan (1986) stress that women base their decisions in a context of human relationships; the perception is that caring for another is important and valid. They have different voices, values, and perspectives than men who traditionally hold the power in health care institutions (Mason, Costello-Nikitas, Scanlan, & Magnuson, 1990). This could indicate that nurses may tend to choose the conflict management strategy of compromise or collaboration to maintain the relationship. Further research related to gender is recommended.

Walton and McKersie (1965) list the effects of conflict as ambiguity in departments, establishment of physical barriers, and inequities in work loads and reward. Decreased morale, high turnover rates, disorganization, decreased productivity, and diminished patient care are additional negative effects (Stern, 1982). Positive effects are that conflict can enhance interpersonal relations, and promote organizational effectiveness (Jones, Bushardt, & Cadenhead, 1990). These also may be areas to suggest for further research as this study did not discuss effects of conflict or leadership styles.

IMPLICATIONS FOR THEORY

Strader (in Decker and Sullivan, 1992) presents the *nursing process* as a conflict management model. Interestingly enough, four of the supervisors interviewed in this study consciously used this format, and the remaining four applied the *nursing process*, though did not identify it as such. Perhaps a subconscious, automatic use of the *nursing process* with the client as the focus explains nursing managers' ease of application of this model, as they replace the client with the conflict participants. Little research on this particular application of the *nursing process* exists, (Strader's model can be seen in Appendix E) and further research on this specific application of the

theory of the *nursing process* would substantiate its applicability for improving effectiveness, efficiency, and quality in community health settings.

Application of the models described by Thomas (1976), Hoy (1987), and Strader (Decker & Sullivan, 1992) will further the testing of the models in actual settings, and model refinement will occur. Another conclusion drawn from this study is that structural and procedural changes in community health are underway, and supervisors are recommended to explore information available on adaptation and environmental change to maintain harmony within the clinic setting. Chaffee (cited in Hall, 1989, p. 250) stresses the importance of transformation leadership, or the degree of satisfaction of the higher needs of organizational members, and Weick (cited in Hall, p.259) emphasizes that environmental change requires that people and their actions change.

IMPLICATIONS FOR PRACTICE IN REGIONAL SUPERVISION

Community health needs strong system-wide proposals rather than small personal interest programs, as well as much more evaluative research. Daft, (cited in Hall, 1989, p.3) states

> The supervisor as leader must determine the organization's goals and strategies, and therein adapt the organization to a changing environment.

Cooperative learning is more effective when there is a low level of conflict, therefore teambuilding exercises that require a great deal of cooperation may not be very successful when high levels of conflict exist.

Workshops conducted by the professional association or offered by external consultants such as the Alberta Teachers' Association would benefit managers in several areas of nursing, not only community health. A simulated program using problem based learning would advance practitioners' skills and

abilities in the area of conflict management, and could be patterned after the Principalship Program offered by the department of Educational Administration at the University of Alberta. The Alberta Association of Registered Nurses might consider pursuing the development of conflict management workshops for their members.

Peer support and upper management support for regional supervisors would facilitate conflict management in what is often described as a "lonely" position. Presently, augmentation of skill development occurs through real life experiences, and could be maximized via staff development programs for regional supervisors. Professional development in leadership skills, conflict management, and implementation of change would provide supervisors with practical relevance to their roles as managers and community leaders, encouraging reflective thinking and inquiry, self and peer confrontation, and sharing of insights (Letiche, van der Wolf and Plooij, 1991). This provides a practice arena for new ideas and skills in a safe situation, and permits structured feedback and coaching.

The drive for excellence exists in nursing; therefore the potential for conflict and motivation exists. Community health administrators, in their search for excellence, should be aware of this, and seek the benefits of combining theory with research in daily practice; reflecting commitment by stressing a client focused practice, a systematic approach to management, encouraging staff development, and developing long term planning.

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Appendix A

Management Position Description of Regional Supervisors

(from the position description of Health Services of X city)

Reporting to the Director of Nursing the Regional Supervisor is responsible for the planning, organizing, directing and evaluating of high quality public health nursing service in the region. Each region serves approximately 50,000 people.

Subordinates reporting to this position are:
Assistant Supervisor
Public Health Nurse
Communicable Disease Control Nurse
Infant and Preschool Nurse
Clinic Receptionist
Health Aide

Staff ranges from 11 - 22; there is no direct budget control.

The regional Supervisor carries broad managerial responsibilities for planning, organizing, coordinating, directing and evaluating nursing programs and resources.

1) Participates with nursing administration and field staff in the formulation, communication, and interpretation of the philosophy, objectives and policies of the Nursing Division.
2) Is the key communications link between the administration and the field staff and is the essential agent in adapting nursing programs and policies to the specific needs of the region.
3) Is responsible for hiring and the day-to-day supervision of Nursing Division staff assigned to the region; must plan staffing patterns and oversee the orientation, ongoing professional development and annual performance review of Nursing Division staff members.
4) Is responsible for the general supervision of non-nursing staff assigned to the region in relation to their accommodation, orientation, and general deportment.
5) Is responsible for ensuring the adequacy and maintenance of the health centre's physical plant, non-technical equipment, supplies and furnishings.
6) Routinely monitors the health needs of the community via several methods including research studies and community liaison; must collaborate in planning nursing services based on those needs, making most efficient use of existing resources.
7) Evaluates the effectiveness and efficiency of nursing programs in meeting regional health needs.
8) Facilitates the smooth functioning of public health programs across the city by means of a communication system of records, reports, policies, manuals, files and procedures.

9) Coordinates student experiences at the regional level to facilitate the achievement of learning objectives.

Specific Accountabilities

In order to achieve its general accountability, this position must

1. Ensure a high standard of public health nursing services in the region.
2. Oversee the implementation of nursing policies, goals and objectives at the regional level.
3. Provide leadership to nursing division staff within the region.
4. Work in close collaboration with other divisions and with other community agencies and organizations.

Appendix B: Schematic Depiction of Research Design

MONTH	SEMESTER		R		ACTION AND ANALYSIS (INVENTION)		
1991			E		Entry to Community		
May	Spring	A	V	P	Pilot study	R	
Jun	Summer	U	I	E	Interview schedule revised	E	T
Jul		D	E	E	Presentation at 35th Anniversary	F	Y
Aug	Fall	I	W	R	Conference	L	P
Sept		T			Ethics approval	E	O
Oct			O	G	DATA COLLECTION (DISCOVERY)	C	L
Nov		T	F	R	- interviews conducted	T	O
Dec	Winter	R		O	Audiotapes transcribed	I	G
1992		A	L	U	Member check	O	Y
Jan		I	I	P	- diary notes & field notes	N	
Feb		L	T		maintained		E
Mar	Spring		E	S	DATA ANALYSIS (INTERPRETATION)		M
Apr			R	E	AERA Conference		E
May			A	M	EXPLANATION (DOCUMENTATION)		R
Jun	Summer		T	I	Writing and Revisions		G
			U	N	- reports to participants		E
			R	A			N
			E	R			C
							E

THESIS

Appendix C: Interview Guidelines

1. What educational degrees have been granted to you?
2. Could you please provide a brief work history?
3. How many years have you worked in a supervisory position?
4. How many years have you worked in your current position?
5. Did you receive any orientation to your current position?
6. Is there anything unique about the community population this health centre serves that effects the work approach?
7. Please describe a particularly challenging, out-of-the-ordinary situation you have encountered as a supervisor.
8. Identify the role of others involved in the situation.
9. What was the cause of the situation and the circumstances that led up to it?
10. Describe the steps taken to manage this situation by you. and by others.
11. Were there any influencing factors for action that stand out?
12. What was the response of those involved?
13. What were the outcomes?
14. What was the effect on you; others; the organization?
15. On a scale of one to five, with the ranking of five being highly positive, and the ranking of one being highly negative, rate the success of the management of this situation.
16. What skills are necessary to deal with situations like this?
17. Would a change in agency organization be recommended?
18. What kind of preparation should one have for this job?
19. Do you wish to make any concluding remarks?

Appendix D: Data Analysis - Constant Comparative

Interviewing - field notes

↓

Transcribing - diary

↓

Member check

↓

Split screen computer analysis coding

↓

285 categories of strategies

↓

Additional coding

↓

107 categories of strategies

↓

Split screen computer analysis - coding

↓

46 requisite skills 206 types 186 sources

38 strategies - analysis continues

↓

Final data collapse

↓

12 skills 5 types 8 sources 10 strategies

↓

Writing thesis

Appendix E: Nursing Process

Stanhope and Lancaster (1988) define the nursing process as, " a systematic method of collecting data and formulating a care plan in order to provide the most appropriate nursing intervention. In the interest of accuracy nurses must not only collect data, but they must make inferences from the data they already have about where to search next for more data."(p.351) It is a framework for analyzing the health of target groups and of a community. (Cookfair, 1991, p.vii).

The phases of the nursing process are similar to the scientific method, and follow the steps of assessment, diagnosis, planning, implementing interventions, and evaluating the interventions.

Definitions of the terms are adapted here for use in conflict management (Cookfair, 1991; Strader in Decker and Sullivan, 1992).

Assessment - the act of collecting data to diagnose a problem; determining the type of conflict, source of conflict and to identify participants and those affected

Diagnosis - a description of the human response to a problem

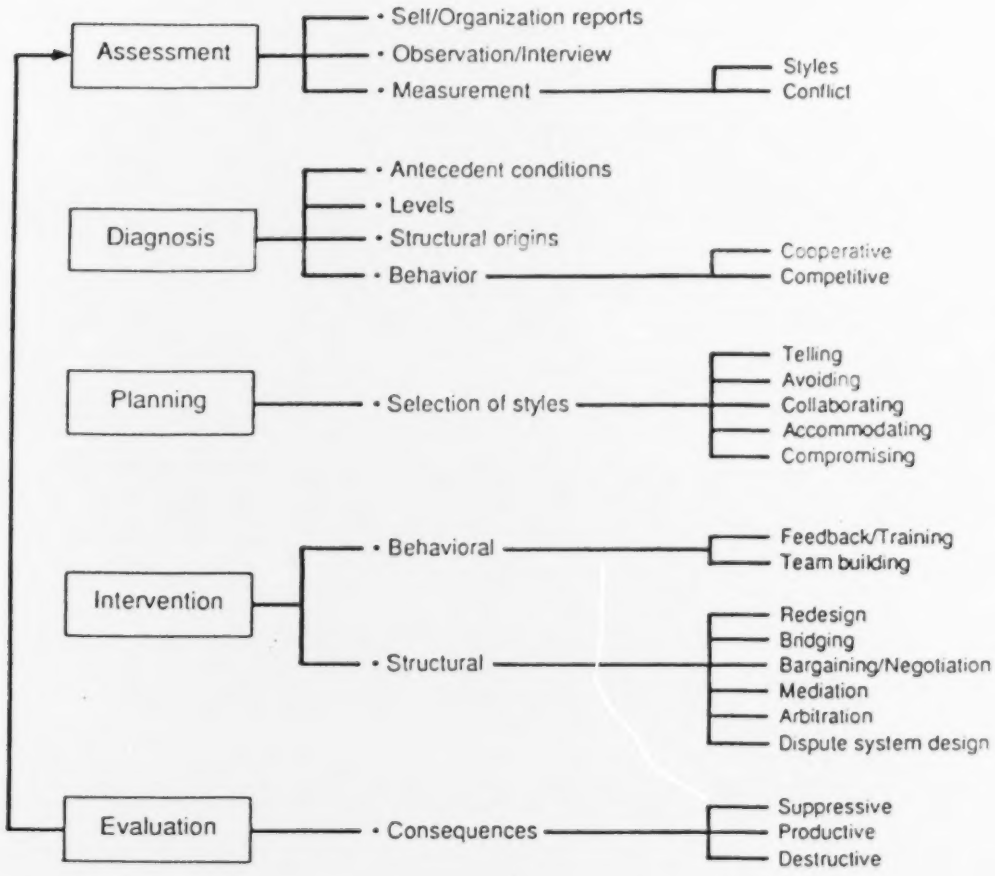
Planning - strategic planning and goal setting in terms of data collected.

Implementation - the plan is put into action

Evaluation - appraisal of reaction of the target person or group to the intervention.

Strader (in Decker and Sullivan, 1992) supports the use of the nursing process as a means of conflict management, and has proposed an adaptive model.

Strader's Conflict Management Model based on Nursing Process



Conflict Management Model

Decker. P., & Sullivan, E. (Eds.) (1992). *Nursing administration: A micro/macro approach for effective nurse executives.* Toronto, ON: Appleton & Lange. p. 557.

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